**EMPLOYEE REASONABLE ACCOMMODATION REQUEST FORM**

Faculty and staff with disabilities are requested to complete this form so that appropriate personnel can plan for services/assistance requested. Written documentation from a professional health care service provider is necessary when requesting disability accommodation. Employees are encouraged to provide complete, candid, and realistic information concerning the nature of the disability, special needs, or any support services required. This information will assist us in determining your ability under the Americans with Disabilities Act (ADA) and will be retained in a confidential manner, separate from the employee’s personnel file.

Name: Date:

EWU ID Phone:

Address:

City/State/Zip:

Position: Department:

Supervisor:

TO BE COMPLETED BY EMPLOYEE: (Use separate sheet if necessary)

Identify and describe the physical or mental disability which is the basis for your reasonable accommodation(s):

What major life activity is substantially limited by this disability?

What do you need to be able to do your job?

**EMPLOYEE CONSENT TO RELEASE CONFIDENTIAL INFORMATION**

Purpose of Disclosure of Information:

To determine eligibility for services and accommodations in the post-secondary employment setting (as outlined in Section 503 of the Rehabilitation Act of 1973 and Title I of the Americans with Disabilities Act of 1990)

Name of Employee:

Job Title:

Department:

Work Schedule:

To:

Name of Health Care Provider

Address:

Street City State Zip

Phone:

Patient’s Date of Birth:

I hereby authorize the above listed health care provider and any others who have treated me to release to Eastern Washington University the following information related to my health care: diagnosis of relevant condition(s), treatment plan, and my ability to perform my work with or without reasonable accommodation, recommendations, history, reports, and correspondence. I also authorize disclosure and discussion as necessary so that EWU may determine appropriate and reasonable accommodations for me. I understand that information obtained under this release is a confidential medical record and is maintained separately from my personnel file. This authorization is valid until revoked by me.

I also understand that EWU may require me to undergo testing or evaluation by medical personnel or vocational rehabilitation specialists selected by EWU, at EWU's expense, for the purpose of establishing the existence and extent of my disability, and my ability to perform job-related functions with or without reasonable accommodation. I further understand that EWU is not obligated to provide any specific accommodation I request, but will evaluate my request in light of all information available in making a determination of what is a reasonable accommodation.

Employee Signature: Date

Revised 10/17/16