REASONABLE ACCOMMODATION REQUEST FORM

(THIS FORM TO BE COMPLETED BY THE APPLICANT/EMPLOYEE)

All Information provided will be kept confidential, to the extent provided by law.*

Please complete this form and submit a copy to University Benefits. If you are requesting a reasonable accommodation related to a disability or other medical-related reason, please also submit a copy to your certified health care provider, along with copies of the Health Care Provider Release Form, to be completed by you, and the Health Care Provider Statement Form, to be completed by your health care provider.

SECTION 1: APPLICANT/EMPLOYEE INFORMATION		
Name:		L - RE $SSOLFL L &XUUHQW (P L 2WKHU
Address:		Phone #: Email:
EMPLOYEE INFORMATION: Complete this section if you are a current employee		
Department/Unit:	Job Title:	
Work Phone #:	Manager:	Campus/Location:

APPLICANT INFORMATION: Complete this section only if you are a

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting