

Northwestern Health Sciences University

REQUEST FOR ACCOMMODATION

The purpose of this form is to document your request for reasonable accommodation to enable you to perform the essential functions of your job. In order to evaluate your request, we will need information regarding your disability, your functional limitations and your requested accommodation(s). Please complete and return this form to your supervisor.

General Information

Name (Last) (First) (MI)

Social Security Number

Job Title

Work Telephone Number

Department/Division

Home Telephone Number

Disability and Accommodation Information

Describe the nature of your disability: _____

Specify how your disability limits your ability to perform essential job function of your position:

Specify the nature of your requested accommodation(s), including any equipment, aids or services:

Attach doctor's written explanation of the requested accommodation and the reason therefore.

A determination regarding your request will be made within thirty working days of your supervisor's receipt of this form. If you wish to appeal the determination, you may file a grievance through the University grievance process.

Employee Signature _____ Date _____

Supervisor Signature _____ Date Received _____

To Be Completed By Human Resource Office

Request approved: _____
Date

Request denied: _____
Date

Approved accommodation/s: _____

Signature: _____

Date: _____
