



Appendix A

**Grinnell College
Reasonable Accommodation Request Form**

The purpose of this form is to assist the College in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of his or her job safely and effectively. This form must be filed separately from the employee's personnel file and be treated confidentially.

Department _____

SECTION 1: Employee— To be completed by employee requesting accommodation.

Employee: _____ Campus phone _____

Campus Box _____

Job Title _____

Supervisor _____

I give the Grinnell College ADA Officer permission to explore my reasonable accommodation request as related to the Americans with Disability Act, as amended. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements.

I further understand that I am required to complete and sign the attached release of information giving Grinnell College permission to consult with my health care professional(s) in order to determine that I am a qualified employee with a disability and to seek guidance as to any functional limitations based on my disability.

Date _____ Employee's signature _____

Please answer the following questions to assist us in understanding the basis and nature of your request for an accommodation (attach additional sheets if necessary).

What are the limitations caused by your condition(s) that you are currently experiencing?

Given your limitations, what parts of your assigned job duties are impeded by your condition?

In order to get us thinking about an effective accommodation, tell us what changes are needed in some duty now part of the job, or the way the job is now done to make it possible for you to continue to do the job well.

SECTION 2: Employer—To be completed by the employing department.

Has the employee signed a Reasonable Accommodation Request Form (Section 1)?
___ **Yes** ___ **No** If no, request signature. (Copy given to the employee.)

Has an Essential Job Function Analysis been completed?
___ **Yes** ___ **No** If no, complete attached Job Function Analysis Form.

SECTION 3 ADA Office -- To be completed by ADA Officer.

Send a copy of the following to the health care providers:

- The signed Health Care Provider Release Form
- Essential Job Function Analysis form.
- Job Description
- Cover letter (attached)

After receiving documentation from the health care provider(s):

Has a health care provider documented that the employee has a physical or mental impairment that substantially limits the employee's ability to perform essential job functions?
___ **Yes** ___ **No**

Recommendations:

Has the Job Accommodation Network been contacted? Yes _____ No _____ If yes,

Recommendations:

Other contacts, please list below:

Accommodation Request is: _____ Approved _____ Denied _____ Other

List specific reasonable accommodation(s) approved:

Name of person completing form: _____

Phone _____ Email Address _____ Date _____

Estimate cost of accommodation if known: _____