



**VALDOSTA STATE UNIVERSITY EMPLOYEE
ACCOMMODATION REQUEST FORM**

EMPLOYEE NAME _____ **VSU ID#** _____

JOB TITLE _____ **FTE** _____

COLLEGE/DEPT _____ **PHONE** _____

SUPERVISOR'S NAME _____ **PHONE** _____

WORK SCHEDULE (DAYS AND HOURS) _____

WORK LOCATION _____

(If you need more room to answer any questions below, please check the back of this sheet)

Please describe the physical, mental or cognitive impairment(s) that limit your ability to do your job.

Please describe the essential functions of your job.

Describe how your impairment(s) limits your performances of the essential functions listed above.

Describe the accommodations you are requesting. Be as specific as possible (i.e. if you are requesting a piece of equipment or a device, please provide description, manufacturer, cost, where to order, etc.)

Describe how the requested accommodations will enable you to perform the essential functions of your job.

Please provide any other information that might help Valdosta State University to evaluate your request.

I give Valdosta State University's Offices of Equal Opportunity Programs & Multicultural Affairs, Human Resources and Employee Development /or Academic Affairs, permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act (ADA). By signing below, I further authorize and give permission to Valdosta State University to secure documentation and information from my physician and/or health care professional regarding my request for reasonable accommodations. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements and the Health Insurance Portability Accountability Act of 1996 (HIPPA).

I further understand that I will be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job.

Signature _____ Date _____