

5. Is the need for accommodation(s) likely to be temporary or permanent? If temporary, how long do you estimate the need for accommodation will exist?

Provider name (please print)

Professional license or specialty

Signature

Date

CONFIDENTIAL

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 their job safely and effectively. This form must be filed separately from the employee's personnel file and be treated confidentially.

SECTION I:

To be completed by employee requesting accommodation.

Employer:	Telephone:
Job Title:	Request Date:
Department:	

I give the State University of New York College at Cortland permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act and the New York Human Rights Law. I understand that all information obtained during this process will be maintained and used in accordance with confidentiality requirements of those statutes.

I further understand that I may be required to complete and sign the attached release of information, giving SUNY Cortland 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 and potential accommodations.

Employee Signature

Date

Employee Name (please print)

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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).

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

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

C. In order to get us thinking about an effective accommodation, tell us what accommodation(s) you envision to make it possible for you to continue to do the job well.

SECTION II:

To be completed by Human Resources

1. Send a copy of :
 - a. The signed Health Care Professional Release Form
 - b. ADA Position Description w/ attachments Form
 - c. Job Description (or current performance program)
 - d. Cover letter

To the health care professional(s) (where applicable).

2. After receiving documentation from the health care professional(s) answer the following:

Has a health care professional documented that the employee has a physical or mental impairment that substantially limits the employee's ability to perform essential job functions?

Yes _____ No _____ Other _____ If yes or other,

Recommendations: _____

