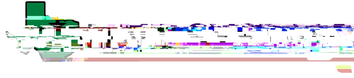

Request for Disability Accommodation in Employment

7KLV IRUP LV DQ LQLWLDO VWHS LQ SURFHVV WR HQVXUH HTXDO HPSOR\PHQW RSSRUWXQLW\
SHRSOH ZLWK GLVDELOLWLHV $Q DFFRPPRGDWLRQ LV GHILQHG DV D UHDVRQDE
DSSOLFDWLRQ SURFHVV WKH ZRUN HQYLURQPHQW DQG RU WKH PDQQHU DQ
RU GHVLUHG LV FXVWRPDULO\ SHUIRUPHG

7KH 6\VWHP RU 8QLYHUVLW\ LQ HYDOXDWLQJ \RXU UHTXHVW PD\ DOVR UHTX
LQIRUPDWLRQ IURP \RXU PHGLFDO SURYLGHU RWKHU LQIRUPDWLRQ JDWKHUHG
UHDVRQDEOH DFFRPPRGDWLRQ WR WKH H[WHQW DOORZHG E\ ODZ LV FRQILGH
5HVRXUFHV NHSW VHSDUDWH IURP SHUVRQQHO ILOHV DQG ZLOO EH DF
6XSHUYLVRUV PDQDJHUV ZLOO EH LQIRUPHG RI QHFHVVDU\ ZRUN UHVWULFWLR

1DPH 1&Ë‡°%ª ì Z¡ Ìf` a ŽË @ D , S.Ì° `ª3ì Z T° TÀ

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'HVFULEH WKH GLVDELOLW\ (please attach medical documentation, if available)

'HVFULEH WKH VSHFLILF SUREOHP RU GLIILFXOW\ DVVRFLDWHG ZLWK
IRU ZKLFK \RX DUH VHHNLQJ UHDVRQDEOH DFFRPPRGDWLRQV

'HVFULEH WKH VSHFLILF DFWLRQ V FKDQJHV HTXLSPHQW RU PRGLI
DFFRPPRGDWH \RXU GLVDELOLW\ DQG KHOS \RX SHUIRUP

([SODLQ LI DSSOLFDEOH DQ\ UHVRXUFHV \RX DOUHDG\ KDYH KDYH D
SURYLGH WKH DFFRPPRGDWLRQ V UHTXHVWHG

1DPH RI 3ULPDU\ 0HGLFDO 3UDFWLWLRQHU 3K\VLFLDQ __________ 3KRQH __________
1RW UHTXLUHG IRU $SSOLFDQWV

(PSOR\HH $SSOLFDQW 6LJQDWXUH ____________________ 'DWH __________

My signature indicates my permission for +XPDQ 5HVRXUFHV to contact my medical practitioner to seek additional or clarifying information and for the medical practitioner to release such information as applicable IRU the evaluation of my request for accommodation. The information provided by me is true and correct to the best of my knowledge.

Please return the completed form to WKH 817 6\VWHP 2IILFH RI (TXDO 2SSRUWXQLW\
)D[
(PDLO :RUNSODFH $FFRPPRGDWLRQV#XQWV\VWHP HGX