REASONABLE ACCOMMODATION REQUEST FORM

TO BE COMPLETED BY THE EMPLOYEE

This form should be completed by the employee who wants to request a reasonable accommodation from the University of St. Thomas. Upon completion, this form must be delivered to Human Resources Department and will be retained separately from the applicant’s or employee’s personnel records.

The purpose of this form is to assist the University in determining whether or to what extent a reasonable accommodation is required for an employee to safely and effectively perform the essential functions of his or her job.

Employee Information:

Employee Name: __________________________

Job Title: ___________________________ Employee ID#: ___________________________

Department: ___________________________ Supervisor: ___________________________

Request for Reasonable Accommodation:

1. Identify and describe the physical or mental disability, illness, condition or disease which is the basis for your request for reasonable accommodation(s) by the University (see definition of “disability” at the bottom of page 2):

________________________________________________________________________________

2. Identify and describe the essential function(s) of your job or the job you are seeking which you are unable to perform without reasonable accommodation(s) by the University (see definition of “reasonable accommodation” at the bottom of page 2):

________________________________________________________________________________

3. Identify and describe the reasonable accommodation(s) needed to enable you to properly and safely perform the essential functions of your job or the job you are seeking, including special equipment, changes in the physical layout of the job, or other accommodations:

________________________________________________________________________________

4. Identify and describe any special methods, skills or procedures which would enable you to perform the essential functions of your job or the job you are seeking:

________________________________________________________________________________
5. Identify and describe any equipment, aids, or services that you are willing to provide and utilize:

______________________________________________________________________________

6. Fax the attached Physician’s Form to your provider. Your provider should fax the completed form to:
   Alaina Ericksen, HR Benefits Office @651-962-6524

______________________________________________________________________________

**Employee Authorization:**

I hereby authorize my health care providers and any others who have treated me to release to the University of St. Thomas Human Resources Department information concerning the disability disclosed herein and provide any opinions to them concerning my ability to perform essential job-related functions with or without reasonable accommodation.

I certify that I have read and reviewed the job description for my job and/or have been informed of the essential functions of my job. I further certify that the foregoing statements are complete, accurate, and true to the best of my knowledge, and I understand the University may require me to undergo testing or evaluation by medical personnel retained by the University for the purpose of establishing the existence and extent of my disability, illness, condition, or disease and my ability to perform essential job-related functions with or without reasonable accommodation.

Employee’s Signature: ___________________________ Date: __________________

**Definitions:**

“Disability” includes a physical or mental impairment that substantially limits one or more major life activities. Major life activities include such things as caring for oneself, performing manual tasks, walking, sitting, standing, lifting, reaching, seeing, hearing, breathing, learning, and working.

“Reasonable accommodation” includes any modification to the job or work environment to enable an employee to perform the essential functions of the job in question.

These definitions are provided only as a guide for completing this form. Nothing in this form is intended to alter the legal definitions of these terms or impose obligations on the University not required by law.

______________________________________________________________________________

Please submit the completed form to Alaina Ericksen, HR-Benefits Office, at 651.962.6524.