

The University of Alabama at Birmingham  
**Employee Accommodation Request Form**  
**Request for Reasonable Accommodation**

APPLICANT INFORMATION  
*(Attach supporting documentation)*

Student Worker	Staff	Faculty
Applicant Name:	BlazerID:	Employee ID:
Email:	Work Phone:	Cell Phone:
Current address:		
City:	State:	Zip Code:
Department/School:	Supervisor:	Supervisor Phone:

DISABILITY REQUIRING ACCOMMODATION

**Accommodation Requested** (Check box below):

Adjustment or Modification of Examination/Training	Facilities	Reassignment	Materials or Policies	Job Restructuring	Parking
Modifying Equipment or Devices	Part-time or Modified Work Schedule		Readers or Interpreters	Other	

**Please describe the physical, mental or cognitive impairment(s) which limits your ability to perform the essential functions of your job.**


**Is your impairment temporary or permanent? If temporary, how long do you expect to be impaired?**


**Describe how your condition limits your ability to perform the essential functions of your job.**


**Describe the accommodation(s) 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, if known)**


**Describe how the requested accommodation(s) will enable you to perform the essential functions of your job.**


**Please describe any other information that might help UAB evaluate your request.**


I have voluntarily completed this Employee Accommodation Request Form and all information provided is true and accurate. I give UAB permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate University personnel and/or my health care professional, and acknowledge that such communication is job-related and consistent with business necessity. 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 may 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.

<b>Applicant Signature:</b>	<b>Date:</b>
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AREA BELOW FOR OFFICE USE ONLY

Request Granted	From (date):	To (date):
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Request Denied (*Please state reason for denial*)

**Notes and/or Description of Accommodations:**  
*(If cost exceeds \$500, approval of Executive Director of Employee Relations is required)*

UNIVERSITY SIGNATURES

Initial Contact Person:	Date:
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Executive Director, Employee Relations:	Date:
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