



Department for Disability Support Services

Office of the ADA Coordinator

East Carolina University

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Accommodation Request Form

East Carolina University is committed to compliance with the Americans with Disabilities Act (1990) and the Americans with Disabilities Amendments Act (2008). The purpose of this form is to Assist East Carolina University in determining whether, or to what extent, a reasonable accommodation will allow an employee to perform the essential functions of his or her job safely and effectively.

Name: _____ Department: _____

Position: _____ EPA Faculty ___ EPA Staff ___ SPA ___ Perm ___ Temp ___

Banner ID: _____ Work phone # _____ Home/Cell _____

Name of Supervisor _____ Supervisor phone # _____

The statutory definition of disability is *a person with a physical or mental impairment that substantially limits one or more of the major life activities of such individual.*

According to the Americans with Disabilities Amendments Act, *major life activities* may include but are not limited to the following, please check all that are impacted by your physical or mental impairment:

- | | |
|--|--|
| <input type="checkbox"/> caring for oneself | <input type="checkbox"/> bending |
| <input type="checkbox"/> performing manual tasks | <input type="checkbox"/> speaking |
| <input type="checkbox"/> seeing | <input type="checkbox"/> breathing |
| <input type="checkbox"/> hearing | <input type="checkbox"/> learning |
| <input type="checkbox"/> eating | <input type="checkbox"/> reading |
| <input type="checkbox"/> sleeping | <input type="checkbox"/> concentrating |
| <input type="checkbox"/> walking | <input type="checkbox"/> thinking |
| <input type="checkbox"/> standing | <input type="checkbox"/> communicating |
| <input type="checkbox"/> lifting | <input type="checkbox"/> working |

Also included are functions of

- | | |
|---|---|
| <input type="checkbox"/> the immune system | <input type="checkbox"/> normal cell growth |
| <input type="checkbox"/> digestion | <input type="checkbox"/> circulation |
| <input type="checkbox"/> the bowels | <input type="checkbox"/> neurological processes |
| <input type="checkbox"/> the bladder | <input type="checkbox"/> the brain |
| <input type="checkbox"/> reproduction | <input type="checkbox"/> respiration |
| <input type="checkbox"/> the endocrine system | |

Other: _____

Please describe the physical or mental impairment(s) for which you are requesting accommodation:

What are the limitations or restrictions caused by your condition(s)? _____

Is the condition permanent? _____ Temporary (If so how long?) _____

If the condition is episodic and does not limit you on a daily basis, how often do you experience symptoms that will necessitate accommodation? _____

Have any accommodations or adjustments been put in place by your supervisor? _____

If yes, please describe:

Have the accommodations been successful? _____

What accommodations or adjustments to the workplace will assist you in performing the essential functions of your job?

By my signature below, I agree that, in order to assist in the development of reasonable accommodations, the ADA Coordinator may share relevant information from my health care professionals with my immediate supervisor(s).

Other offices on campus that may be consulted on a case by case basis include:

- Human Resources for analyses of essential job functions and options related to FMLA, short and long term disability
- The Office of Prospective Health when a fit for duty evaluation is indicated
- Environmental Health & Safety to assist with ergonomic and safety issues
- Facilities when physical adjustments to the workplace are needed

I understand that I must also submit the “ADA Disability Verification Form” completed by my appropriate health care provider, to the Office of the ADA Coordinator.

Signature

Date