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:

- caring for oneself
- performing manual tasks
- seeing
- hearing
- eating
- sleeping
- walking
- standing
- lifting

- bending
- speaking
- breathing
- learning
- reading
- concentrating
- thinking
- communicating
- working

- normal cell growth
- circulation
- neurological processes
- the brain
- respiration

Also included are functions of

- the immune system
- digestion
- the bowels
- the bladder
- reproduction
- 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).

__________________________________________________________
Signature

__________________________________________________________
Date

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.