Documentation
ADA Request for Accommodations

Employee Name	ID#	Date of Birth
Campus or Department	Position	Name of Supervisor

1. Describe/name the condition/disability that limits your performance of specific responsibilities.

2. My disability is ☐ temporary or ☐ permanent.
3. List/describe limitations in your job responsibilities (be as specific as possible).

4. Accommodations are being requested so you can meet the requirements of your job functions.

☐ Please attach doctor or medical statements documenting the limits on your ability to perform your responsibilities.

Employee Signature Date

To be completed by HR Designee

☐ Verified all required documentation/information ☐ Employee qualifies
☐ Accommodations offered by the district:

☐ Accommodations reviewed by the employee and accepted
☐ Accommodations reviewed by the employee and did not accept
☐ Notification of employee's direct supervisor, _____

Employee's Signature: _____ Date: _____

HR's Signature: _____ Date: _____

Retention: ADA requires at least one year. GR1050-22b states until superseded + 2 years and should be kept where medical information is kept separate from the employee's personnel file.
Date of Destruction: _____
This institution does not discriminate based on race, religion, color, national origin, gender, sex, or disability in providing education services, activities, and programs per Title VI of the Civil Rights Act of 1964, Title IX of the Educational Amendments of 1972 and section 504 of the Rehabilitation Act of 1973.

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