

ACCOMMODATION REQUEST FORM

The University of South Florida is committed to equal opportunity in all aspects of employment. This form is intended to assist in determining whether, and to what extent, a reasonable accommodation is necessary and available for an employee with a disability to perform the essential functions of his or her job. The information you provide will be kept confidential consistent with state and federal laws. Information may be shared with supervisors and managers to the extent necessary to engage in the interactive process regarding necessary accommodations. Health and safety personnel may be informed if the condition might require emergency treatment. Government and University officials investigating compliance with applicable laws might be informed on the information disclosed.

EMPLOYEE INFORMATION:

Name: _____ Department: _____

Position/Title: _____ Employee # _____

Best daytime contact telephone #: _____

Email address: _____

Immediate Supervisor: _____

Current work schedule/shift/days worked:

University official(s) contacted about accommodation:

DISABILITY INFORMATION:1. Please indicate the nature of your disability¹:

<input type="checkbox"/> Visual	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Mental/Psychological
<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Mobility	<input type="checkbox"/> Neurological	<input type="checkbox"/> Other (please specify)

¹ In general, *for purposes of this form the term "disability"* means a physical or mental impairment that substantially limits one or more of the major life activities of an individual.

2. Is your disability:

_____ Temporary (If so, how long?) _____

_____ Permanent

3. Please briefly explain any limitations or restrictions caused by your disability:

4. Please list any accommodation(s) or service(s) related to your disability that would help you meet the essential functions of your current job:

5. If you are requesting a leave of absence as an accommodation, please check any boxes below that apply to the requested leave:

- ☐ With pay or partial pay, using accrued sick, annual, or other leave types
- ☐ Leave without pay (LWOP).
- ☐ Sick Leave Pool hours (if eligible—additional documentation may be required).
- ☐ Not Applicable

I hereby agree that Central Human Resources can share relevant information from my physician or other health care provider(s) with the supervisor(s) in my immediate work unit and with other University offices that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work responsibilities.

Central Human Resources also has my permission to contact my physician or other health care provider(s) for additional information to assist in developing reasonable accommodations for me.

I understand that I must also submit the **“ADA Interactive Process Health Care Provider Questionnaire”** form signed by an authorized physician or other health care provider. This form should include a description of my disability; any related limitations; and recommendations for accommodation(s) and/or service(s). I understand that completion of these forms is not a guarantee of approval for the requested accommodation.

If I request and receive an approved leave of absence as an accommodation, it is my responsibility to communicate with my supervisor and Departmental Leave Coordinator to request and/or verify the type and number of hours of paid leave to be used. If the anticipated end date of my approved leave changes, it is my responsibility to notify the Central Human Resources (CHR) and submit any required documentation before the end of the original leave, so that any request for extension or modification may be reviewed. While on a leave of absence, I am responsible for continuing payment of my employee share of insurance premiums. Should CHR not receive my completed documentation, and I remain absent from employment with USF, I understand that I may be subject to termination from my position, consistent with USF's policies and regulations regarding attendance and unexcused absences.

Employee Name (Print) and Date

Employee Signature

Please return the completed form to Central Human Resources by:

- Fax: 813-974-5227
- Email: HR-ADA-Request@usf.edu
- Mail/hand delivery:
University of South Florida Central
Human Resources ADA
4202 E. Fowler Avenue
Tampa, FL 33620