THE UNIVERSITY OF RHODE ISLAND

Reasonable Accommodation Request Form

All information regarding an individual's medical condition and the reasonable accommodation request is confidential and only disclosed to persons on a need to know basis. Any and all documents related to this request are kept confidential and will be maintained and used in accordance with applicable state and federal law.

Instructions:

Employees and Applicants for Employment seeking accommodations can make a request at any time.

The procedure for requesting a reasonable accommodation is available on the Office of Human Resource Administration Website:

Reasonable Employment Accommodation for Persons with Disabilities

In order to review a request for accommodation, information is required regarding your medical condition, applicable functional limitations and your requested accommodation(s). We also need authorization to acquire medical information needed to verify the claim of disability and limitations. Therefore, we encourage you to complete this form in its entirety.

If you need help completing this form, someone else may complete it on your behalf, or you may contact the ADA Section 503 Coordinator for assistance.

Upon completion, please forward this form to the ADA Section 503 Coordinator who is responsible for reviewing these requests. Please be sure you sign this form.

University of Rhode Island
ADA Section 503 Coordinator
Office of Human Resource Administration
80 Lower College Rd.
Kingston, RI 02881
Telephone: 401.874.2684 TTY via R.I. Relay 711
Fax: 401.874.5272
Email – mary.previte@uri.edu

☐ Faculty ☐ Staff ☐ Other (specify) _____

Name: _____

Job Title: _____

Department: _____

Work Address: _____

Work Telephone Number: _____

Work Email: _____

Home Address: _____

Home Telephone Number: _____

Home Email: _____

Preferred method of contact: ☐ Home Phone ☐ Home Email ☐ Work Phone ☐ Work Email

I am an employee, or an applicant for the position named above, and may require a reasonable accommodation to perform the essential function(s) of the job, or may need assistance with the application process. I hereby request that the ADA Section 503 Coordinator contact me regarding this need for reasonable accommodation and authorize them to verify this request.

If you are an employee:

Supervisor's Name: _____

Job Title: _____

Department: _____

Work Telephone Number: _____

Work Email: _____

Medical Information

Please identify the medical condition(s) for which you are requesting an accommodation:

I do hereby authorize the University of Rhode Island to acquire the medical documentation needed to verify my claim of disability and limitations on my ability to perform some essential functions of the job or participate in the application process. I further understand that the ADA regulations require information regarding my medical condition or history shall be collected and maintained separately from personnel files and be treated as confidential except:

1. **The University ADA Section 503 Coordinator may review all information provided to verify my claim of a disability, need for a reasonable accommodation and to develop a reasonable accommodation plan;**
2. **The state's rehabilitation /disability services experts may review all information provided to verify my claim of a disability and need for a reasonable accommodation /modification /auxiliary aids, to conduct a job or task analysis and develop a reasonable accommodation plan**
3. **If I am an employee, supervisors and managers may be informed regarding necessary restrictions on my work, duties or participation in services (but not the nature of my disability);**
4. **First aid and safety personnel may be informed when appropriate if my disability might require emergency treatment; and**
5. **Government officials investigating compliance with the ADA or other disability rights laws.**

I authorize: _____

Insert applicant's health care professional's name above

To release my medical records to verify that I have physical and/ or mental impairment(s) that substantially limit one or more major life activity and that these limitations prevent me from performing the essential functions (listed above) of the job or from participating in the application process for a position at the University.

Healthcare Professional's mailing address: _____

City, State, and Zip Code: _____

Office Phone: _____

Applicant's Signature:

Date Signed:

Job and Accommodation Information

Please explain how your medical condition(s) listed in Section B affect(s) your ability to submit an application for a position or perform the essential functions of your position. If you are a new employee, state the anticipated difficulties you foresee in completing your job duties. Be as specific regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

Please provide your recommendations for a reasonable accommodation(s) and any information you may have about any associated costs (attach supporting documentation).

Please describe any accommodations or assistive technologies you currently use.

Please identify any University employee with whom you have discussed this request for a reasonable accommodation (i.e. , co-worker, supervisor, HR, etc.) Please include dates

Please add any comments you feel may be helpful in consideration of your request.