MCAD ADA REASONABLE ACCOMMODATION REQUEST FORM

To request an accommodation, please complete the following request form and submit to Human Resources as soon as the need for accommodation becomes apparent (or as soon as possible thereafter). Depending on the accommodation requested, approval as a reasonable accommodation under the ADA may be contingent on several factors, including but not limited to: medical certification, manager approval, job duties, past approval/rejection of similar accommodation(s), etc. Additional documentation or clarification of documentation, may be required prior to making a final determination to approve or deny an accommodation. MCAD reserves the right to request medical documentation to verify the existence of a disability; and, to appropriately assess your condition, functional limitations, and/or request for reasonable accommodation.

Employee Name (print clearly): _____ Date: ___/___/_____

Position: _____ Dept: _____

Supervisor Name/Position: _____

REQUEST FOR REASONABLE ACCOMMODATION

(Please use additional pages as needed)

1. **NATURE OF THE QUALIFYING DISABILITY:** Please describe the nature, extent, and duration of your disability. Please explain how the impairment(s) listed affect(s) your ability to 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 as possible regarding the job duties you are having difficulty performing or believe you will have difficulty performing. Note: Essential functions are duties that are basic or fundamental to a position.

2. **REQUESTED/SUGGESTED ACCOMMODATION**: Please describe the accommodations you believe are needed to enable you to perform the essential functions of this job. What specific accommodation(s) are you requesting, and how will this accommodation(s) assist you? What, if any, employment privileges are you having difficulty accessing? Please explain.

3. **PHYSICIAN CONTACT INFORMATION (Employees only):** Please provide name, address, telephone and fax numbers. The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations.

4. Provide any additional information that might be useful in processing your accommodation request(s).

I authorize the release of necessary confidential medical information regarding my disability to relevant hiring managers as deemed necessary by Human Resources. I also attest to the fact that a copy of the position description has been given to me for review and reference.

Employee Signature: _____ Date: _____

To signatory: In non-physician review cases, decisions regarding accommodations will be made within 10 business days of the receipt of this form by Human Resources. Due to delays that may be caused in communications with physicians, no specific decision date can be provided for physician review cases.

Return to the Office of Human Resources, M16 or to human_resources@mcad.edu.

Please contact HR with any questions.

For HR use ONLY: Date received: _____ Reasonable Accommodation: Y/N Accommodation Notice sent: _____