Human Resources
A&M-COMMERCE

Accommodation Request Form

This is a confidential form and will be submitted by the requesting applicant/employee directly to Human Resources. Only employees are expected to complete workplace information.

1.) REQUESTOR INFORMATION

Name: _____ _____ _____ _____
First (Given Name) *Middle* *Last (Family Name)* *Maiden or other last name used*

Home/Cell Phone #: _____ Office Phone: _____

Department: _____ Supervisor: _____

Position: _____ UIN: _____

2.) NATURE OF QUALIFYING DISABILITY

3.) REQUESTED/SUGGESTED ACCOMODATION

Please describe the accommodations you believe are needed to enable you to perform the essential functions of this job.
You may attach a separate sheet if necessary.

4.) PHYSICIAN CONTACT INFORMATION (Employees only)

The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations.

Physician Name: _____ Name of Practice: _____

Office Phone: _____ Office Fax: _____

_____ _____ _____ _____
Address *City* *State* *Zip Code*

AUTHORIZATION and SIGNATURE

I authorize the release of necessary confidential medical information regarding my disability to relevant hiring managers as deemed necessary by Human Resources.

Signature: _____ Date: _____

Note to signatory:

- In non-physician review cases, decisions regarding accommodations will be made within 10 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.
- If there are physical requirements are included in your position description you will be asked to review to ensure accuracy.