

CONFIDENTIAL

All information shared with the University through the ADA/ADAAA evaluation and/or reasonable accommodation process will be maintained separate from personnel files and in accordance with all ADA/ADAAA requirements.

Reasonable Accommodation Request Form

Individuals who are employed at Purdue University and are requesting reasonable accommodation(s) under the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008 (ADAAA) are encouraged to complete this form in its entirety. If you are unable to complete this form on your own, someone else may complete the form on your behalf. **Bring this completed form with you to a meeting with the Purdue Evaluator in Human Resources.**

| Date | Name (please print) | | |
|---------------------------|------------------------|--|--|
| Home or Cell Phone Number | Email Address | | |
| Position Title | Department | | |
| Campus Address | Campus Telephone | | |
| Supervisor's Name | Supervisor's Telephone | | |

Questions to Clarify Accommodation(s) Requested and the Reason for the Accommodation Request(s):

1. Identify the physical and/or mental impairment(s) for which you are requesting accommodation(s) and the expected duration of the impairment(s). Include the date of diagnosis.

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2. 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.

3. What specific accommodation(s) are you requesting, and how will this accommodation(s) assist you?

4. What, if any, employment privileges are you having difficulty accessing? Please explain.



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

NOTE: Purdue University 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 Signature

| Name of Person | Completing | this Form, | if not | employee, |
|------------------|--------------|------------|--------|-----------|
| and Relationship | o to Employe | e | | |

Date

Date