



DOMINICAN UNIVERSITY

Date: _____

Employee Name: _____

Phone: _____ Email: _____

Job Title: _____ Department: _____

Supervisor's name: _____

Describe the nature, extent and duration of your disability:

Describe the accommodations you believe are need to enable you to perform the essential functions of this job:

Provide the name, address, telephone and email of your health care provider. The provider may receive a request from us for information regarding your impairment/disability and recommendations for accommodations.

Attach any supporting documentation that may be helpful in evaluation this request for accommodation.

I authorize the release of information regarding my disability to the appropriate party at Dominican University as deemed necessary by Human Resources to facilitate this request for accommodation.

Employee signature: _____

Date: _____
