Disability Accommodation Request Form

UIW complies with all applicable federal and state nondiscrimination laws and prohibits discrimination or harassment based on a disability or pregnancy status. As set out in the Employee Handbook, Chapter 15, UIW will provide reasonable accommodation(s) for a person who has a physical or mental impairment that substantially limits one or more major life activities unless doing so would create an undue hardship for UIW.

Employees requesting reasonable accommodation(s) under the Americans with Disabilities Act of 2008 (ADA) are required to complete this form in its entirety. Please note, all requests for accommodations may not qualify under the ADA.

Section 1: Contact Information (To be completed by the Requesting Employee)

Employee Name:	PIDM:
Telephone:	Email:
Title:	Division:
Department:	Supervisor:
Regular Work Schedule (days/hours; full-time; part-time):	
Work Location:	

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Section 2: Accommodation Request (To be completed by the Requesting Employee)

Please limit your responses to the condition for which you are seeking an accommodation. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

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

B. Explain how the impairment listed above affects your ability to perform the essential functions of your position. Be as specific as possible regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

C. Identify and describe the reasonable accommodations needed to perform essential functions properly and safely.

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D. Add any comments you feel may be helpful in our consideration of your request.

My signature below authorizes the UIW Human Resources Director or designee, permission to explore coverage and reasonable accommodations under the ADA. This may include speaking to appropriate University personnel and/or my health care professionals. I understand that all information obtained during this process will be maintained and used in accordance with the ADA confidentiality requirements. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform essential functions of my job.

Employee's Signature:_____ Date: _____

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Section 3: HEALTH CARE PROVIDER (To be completed by the medical provider.)

Your patient (identified in Section 1) has requested a workplace accommodation, which may qualify under ADA. Please limit your responses to the condition for which the employee is seeking an accommodation. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Please complete the information in Section 3, A-C and please be sure to sign the form on the last page.

A. Please identify the physical or mental impairment.

B. Please describe the effects or limitations this impairment has on the employee's ability to perform his/her job duties.

C. Please describe the duration of this impairment (e.g., long-term, permanent, short-term).

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Thank you for your assistance in providing this information so that we may assess the employee's request.

_____ _____

Signature of Physician or Medical Provider Date

_____

Provider Name (printed)

_____

Specialty or Type of Provider

Forms may be faxed, emailed, or mailed to:

UIW Human Resources Department
4301 Broadway, CPO 320
San Antonio, TX 78209
Fax: 210- 729-6034
uiwhr@uiwtx.edu