

UNIVERSITY OF TOLEDO

REASONABLE ACCOMMODATION REQUEST FORM FOR FACULTY/STAFF

Name \_\_\_\_\_ Job Title \_\_\_\_\_

Classification (Faculty/Staff) \_\_\_\_\_ Department \_\_\_\_\_

Person to whom you report: \_\_\_\_\_

*This form is to be completed whenever a member of the faculty or staff desires to request a reasonable accommodation. Upon completion, this form must be delivered to the Administrator for Human Resources (Staff) or the Director of Faculty Affairs (Faculty).*

THE PURPOSE OF THIS FORM IS TO ASSIST THE MEDICAL COLLEGE OF OHIO IN DETERMINING WHETHER, OR TO WHAT EXTENT, A\*\*REASONABLE ACCOMMODATION IS REQUIRED FOR AN INDIVIDUAL TO PERFORM THE ESSENTIAL FUNCTIONS OF HIS/HER POSITION.

**SECTION I**

(To be completed by the appropriate ADA Coordinator PRIOR to completion of the form by the faculty/staff member.)

- This faculty/staff member has a known or obvious disability. \_\_\_\_\_ (Coordinator Initials)  
Identify the disability \_\_\_\_\_
- This faculty/staff member DOES NOT have a known or obvious disability. \_\_\_\_\_ (Coordinator Initials)

**SECTION II**

(To be completed by the faculty/staff member requesting an accommodation.)

1. Identify your \*disability and describe how it substantially limits you from meeting the requirements of your curriculum. **(THIS QUESTION SHOULD ONLY BE ANSWERED IF THE FACULTY/STAFF MEMBER DOES NOT HAVE A KNOWN OR OBVIOUS DISABILITY AS INDICATED BY THE ADA COORIDINATOR IN THE PREVIOUS SECTION.)**

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2. Identify and describe the essential functions of your position which you are substantially limited from performing without a reasonable accommodation.

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3. Identify and describe the reasonable accommodation(s) needed to enable you to perform the essential functions of your position.

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4. Identify and describe any special methods, skills or procedures that would enable you to perform the essential functions of your position.

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5. Identify and describe any equipment, aids or services that you are willing to provide and utilize.

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6. Please choose between the following options, indicating your choice by checking the appropriate box. **(THIS QUESTION SHOULD ONLY BE ANSWERED IF THE FACULTY/STAFF MEMBER DOES NOT HAVE A KNOWN OR OBVIOUS DISABILITY AS INDICATED BY THE ADA COORDINATOR IN SECTION 1 ABOVE.)**

I have documented my disability by attaching medical records sufficient to demonstrate my disability and need for the accommodation requested above.

**I hereby authorize the following healthcare provider(s) to release to the University of Toledo medical records sufficient to demonstrate my disability and need for the accommodation requested above:** \_\_\_\_\_

(Name of health care provider)

\_\_\_\_\_  
Signature

\* "Disability" is broadly defined to protect individuals with serious disabilities, not minor or temporary impairments. To qualify as disabled under the ADA it must be demonstrated that the individual: (1) has a physical or mental impairment which substantially limits one or more of that person's major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

\*\* "Reasonable Accommodation" includes a modification to the work environment or provision of adaptive devices to enable an individual to fulfill the essential elements of their curriculum.

I CERTIFY THAT I HAVE READ, REVIEWED AND/OR HAVE BEEN INFORMED OF THE FUNCTIONS OF MY POSITION. I FURTHER CERTIFY THAT THE FOREGOING STATEMENTS ARE COMPLETE, ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT FALSE STATEMENTS MADE ON THIS FORM MAY BE CAUSE FOR DISMISSAL. I ALSO UNDERSTAND THAT MEDICAL COLLEGE OF OHIO MAY REQUIRE ME TO SUBMIT ADDITIONAL MEDICAL RECORDS OR UNDERGO TESTING OR EVALUATION BY MEDICAL PERSONNEL RETAINED BY THE INSTITUTION FOR THE PURPOSE OF ESTABLISHING THE EXISTENCE AND EXTENT OF MY DISABILITY, ILLNESS, CONDITION OR DISEASE IN THE EVENT THAT THE MEDICAL RECORDS THAT I HAVE INITIALLY PROVIDED DO NOT SUFFICIENTLY ESTABLISH THE EXISTENCE AND EXTENT OF MY DISABILITY, ILLNESS, CONDITION OR DISEASE.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**SECTION III**

(To be completed by the appropriate ADA Coordinator.)

Was the request for accommodation granted?     Yes             No

If "no," explain: \_\_\_\_\_  
\_\_\_\_\_

When will the accommodation be implemented? (date) \_\_\_\_\_

Comments: \_\_\_\_\_  
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