**Accommodation Request Form**

The University of North Carolina at Chapel Hill is committed to equal opportunity in all aspects of employment for qualified disabled individuals. The purpose of this form is to assist the University of North Carolina at Chapel Hill in determining whether, or to what extent, a reasonable accommodation is necessary for an employee with a disability to perform one or more essential functions of his or her job safely and effectively.

The information you provide will be kept confidential consistent with State and Federal law. Please note that supervisors and managers may be informed regarding necessary accommodations; health and safety personnel may be informed if the condition might require emergency treatment; and government officials investigating compliance with applicable laws may be informed.

**This form must be filed *in addition to* the Self-Identification of Disability form.**

**Employee Information:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | | | | | Gender:  Male  Female | | | |
| Department/Unit: | | |  | | | | Position/Title: | | |  |
| Employment Status:  EHRA  SHRA  Permanent  Temporary | | | | | | | | | | |
| Phone # (Work): | | | | |  | | PID #: | | |  |
| Phone # (Home/Cell): | | | | |  | | Email Address: | | |  |
| Mailing Address (Please include CB# if office address): | | | | | | | |  | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| Supervisor: | |  | | | | | Phone #: | |  | |
| HR Rep: | |  | | | | | Phone #: | |  | |
| Current Work Schedule/Shift: | | | | | |  | | | | |
| Former/Existing Accommodations: | | | | | |  | | | | |
|  | | | | | | | | | | |
| University Offices Contacted: | | | | | |  | | | | |
|  | | | | | | | | | | |
| Date of Hire: | | | |  | | | | | | |

**Disability Information**:

1. Please indicate the nature of your disability:

|  |  |
| --- | --- |
| Visual Impairment | Nervous System/Neurological Disorder |
| Hearing Impairment | Mental/Psychological Impairment |
| Mobility Impairment | Learning Disability |
| Respiratory Impairment | Other (Please Describe) |
| Speech Impairment |  |

1. Is your disability:

|  |  |
| --- | --- |
| Temporary (If so, how long?) |  |
| Permanent |  |

1. Please briefly describe any limitations or restrictions caused by your disability:

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| --- |
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|  |
|  |
|  |

1. Please list any accommodation(s) or service(s) related to your disability that would help you to meet the essential functions of your current job:

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|  |

I hereby agree that the Equal Opportunity and Compliance Office is permitted to share relevant information from my physician or other health care provider(s) with the supervisor(s) in my immediate work unit and other University offices that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work related responsibilities.

I also agree that the EOC Office has my permission to contact my physician or other health care provider(s) for additional information to assist in developing reasonable accommodations for me.

I understand that I must also submit the **“Documentation of Disability”** form signed by an authorized physician or other health care provider. This form should include a description of my disability; any related limitations; and recommendations for accommodation(s) and/or service(s).

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Name

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Signature Date

*The University of North Carolina at Chapel Hill is an Equal Opportunity Employer that welcomes all, including protected veterans and individuals with disabilities.*