Stanford University

**Employee Workplace Accommodation Request Form**

Please provide the following information so we can evaluate your request for a workplace accommodation for your disability.

 Date: \_\_\_\_\_\_\_\_\_\_\_

1. Name/Employee ID:

2. Phone Number/Email:

3. Job Title:

4. Department:

5. Supervisor:

6. Do you have a serious health condition or disability impacting your ability to perform your job duties? [ ]  Yes [ ]  No

If yes, is your condition temporary or permanent? [ ]  Temporary [ ]  Permanent

7. Are you currently seeing a healthcare provider/seeking treatment at this time? [ ]  Yes [ ]  No If yes, do you have a doctor’s note (please attach)? [ ] Yes [ ]  No

If no, please explain:

8. Are you currently working at this time? [ ]  Yes [ ]  No

9. Please describe the physical or functional limitations you are experiencing (e.g. I am experiencing difficulty lifting or I am experiencing difficulty with time management).

10. What job duties are you having difficulty with because of your physical or functional limitations?

11. Please describe the type of accommodation you are requesting that might allow you to perform your job duties (e.g. I am requesting voice recognition software that will assist me with typing.)

12. How will this accommodation assist you (e.g. It will reduce the amount of typing I need to do, allowing me to recover from surgery)?

13. If you are requesting a leave of absence as an accommodation, please describe how a leave of absence will assist you?

14. What is the duration of your requested accommodation?

Start:      End:

15. Do you anticipate returning to your regular job duties at the conclusion of this accommodation period? [ ]  Yes [ ]  No

If no, please explain:

*I certify that I have a serious health condition that is affecting my abilities to work my full job duties and require reasonable accommodation. (Please include original signature)*

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by Supervisor or HRM**

Date received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Supervisor or HRM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of meeting with employee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

cc: Disability File