Reasonable Accommodation Request Form

THIS FORM WILL NOT BE PLACED IN YOUR APPLICATION OR PERSONNEL FILE AND WILL BE MAINTAINED WITHIN THE EEOA OFFICE. THE CONTENTS OF THIS REQUEST WILL BE KEPT IN CONFIDENCE EXCEPT AS NEEDED TO FACILITATE THE ACCOMMODATION. ALL REQUESTS ARE DETERMINED ON A CASE-BY-CASE BASIS.

☐ *Please check this box if you have attached your current job description*

☐ *Please check this box if you are a designated onsite employee*

Name:_____ Job Title: _____

GWID:_____ Email Addresses(s): _____

Dept. Name/School:_____ HR Representative: _____

Supervisor's Name & Title:_____ Supervisor's #: _____

University Designation:_____ In-Office Frequency: _____

Contact Information

Home Address & Phone Number	GW Location Address & Phone Number

Are you eligible for and/or using leave under the Family and Medical Leave Act? Yes No

Are you eligible for and/or using short/long term disability? Yes No

You may attach any medical documentation that may assist us in making a determination in your case; please be advised medical documentation will be required.

Describe the nature of your disability.

_____

_____

Describe how your disability will/may impact your work performance.

_____

_____

Requested accommodation and anticipated duration of accommodation.

_____

_____

Medical Provider(s) Name: _____

Address:_____

Phone Number:_____ Fax Number:_____ Email: _____

I AM REQUESTING AN ACCOMMODATION. TO ASSIST EEOA IN ESTABLISHING MY ACCOMMODATION NEEDS, I AGREE TO PROVIDE ADDITIONAL DOCUMENTATION AND/OR A RELEASE FOR EEOA TO DISCUSS MY ACCOMMODATION REQUEST WITH THE APPROPRIATE MEDICAL PROFESSIONAL.

*Employee Signature:*_____ *Date:* _____

Release of Information Form

I,_____, believe that I have a medical condition that may require an accommodation to allow me to perform the essential functions of my position as _____ at The George Washington University (GW).

Job Title

I hereby authorize my health care provider(s)* who have treated me for my medical condition to provide information to GW relevant to the assessment of whether I am entitled to a reasonable accommodation under the Americans with Disabilities Act.

My health care provider(s) may identify my medical condition that prevents me from performing the essential functions of my job. My health care provider(s) may also discuss and/or release documents which show how the medical condition limits my ability to perform my job, the extent to which I would be able to perform the essential functions of my job with an accommodation, the nature of any such accommodation and the probable duration of the condition.

This release is granted with the understanding that all medical information obtained will be handled in confidence, in accordance with applicable laws. A photographic copy of this authorization shall have the same validity as the original.

*My health care provider(s) is/are_____and can be
Name
reached at_____. His/Her fax number is_____.
Phone Number Fax Number

_____

Employee Signature *Date*

Please submit to EEOA office by email at accommodations@gwu.edu or fax 202-994-9658.