*Americans with Disabilities Act*

**COVID-19 WORK OFF-CAMPUS EMPLOYEE ADA MEDICAL ACCOMMODATION REQUEST**

***This form is ONLY for an employee requesting an ADA medical condition accommodation***

***to work off-campus for reasons relating to the COVID-19 coronavirus pandemic.***

Employee Name: Employee 910 #:

Location: College/Department:

Job Title:

Supervisor Name:

# *Please provide the following information. Use additional pages or provide documentation as needed.*

1. Identify your disability or physical or mental impairment(s) or limitation(s) (“Disability”):
2. Explain how your Disability impairs or limits your ability to perform assigned job duties:

1. Expected duration of the Disability:

1. What specific accommodation(s) are you requesting, if known?
2. If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? If *yes*, please explain or attach information.
3. Has a health care professional recommended a specific accommodation? Please describe or attach documentation:

1. Is your accommodation request time sensitive? If *yes*, please explain.
2. If you are requesting a specific accommodation(s), how will that accommodation(s) assist you to perform you job?

1. Please provide any additional information that might be useful in processing your accommodation request.

Employee *Signature* Date

# *Thank you. Please send completed form to the Human Resources Department: hr-group@eou.edu*

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**COVID-19 WORK OFF-CAMPUS EMPLOYEE ADA ACCOMMODATION RESPONSE**

Employee Name: Employee 910 #:

Location: College/Department:

Job Title:

Supervisor Name:

# Brief description of disability and/or limitation(s) of employee:

# List the essential function(s) of the employee’s position that cannot be performed without an accommodation:

# Describe accommodations that were considered to be possible solutions:

# Accommodation Request was denied; describe reason(s):

# Accommodation Request that was chosen and approved; describe:

# Date the chosen accommodation was implemented:

# Describe any accommodations that failed after being implemented and the replacement accommodations:

# HR Department person conducting the accommodation assessment and implementation:

# Name:

# *Signature*: Date: