RAMAPO COLLEGE OF NEW JERSEY

AMERICANS WITH DISABILITIES ACT (ADA) ACCOMMODATION REQUEST FORM

This request for accommodation of a disability will not be placed in your personnel file. Contents of this request will not be shared with anyone except as needed to consider and to implement, as appropriate, an accommodation for the disability.		
Date of the Request:		
Employee's Name:		
Employee's Position:		
Employee's Work Location:		
Employee's Phone Number		
Employees' Supervisor:		
A. Questions to clarify accommodation requested.		
What specific accommodation are you requesting?		
If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore?	Yes ☐	No ☐
If *yes*, please explain.		
Is your accommodation request time sensitive?	Yes ☐	No ☐
If *yes*, please explain.		

B. Questions to document the reason for accommodation request.		
What, if any, job function are you having difficulty performing?		
What, if any, employment benefit are you having difficulty accessing?		
What limitation is interfering with your ability to perform your job or access an employment benefit?		
Have you had any accommodations in the past for this same limitation?	Yes ☐	No ☐
If *yes*, what were they and how effective were they?		
If you are requesting a specific accommodation, how will that accommodation assist you?		

C. Signature

Please provide any additional information including medical documentation from your healthcare provider via ADA Medical Assessment Form to support your Accommodation request.

_____ _____

Employee's Signature Date

Return this form to Benefits
D-115
201-684-7502
Fax – 201-684-7267

For Human Resources Use Only

Date received:

Processed by:

Date medical documentation received:

Date Accommodation Determination letter sent to employee:

Date Interactive Accommodation process initiated: