UNIVERSITY OF TEXAS AT EL PASO
EMPLOYEE REQUEST FOR ACCOMMODATION

This form is an initial step in processing your request for accommodation under the "Accommodations for Individuals with Disabilities" policy with the University of Texas at El Paso (UTEP). An accommodation is defined as a reasonable modification or adjustment to the job application process or the work environment that enables a qualified person with a disability to perform the essential functions of that job. In order to determine whether you are eligible for accommodations under the Americans with Disabilities Act (ADA), the University will ask that you sign a Release of Information form that permits the University to discuss your medical condition with your healthcare provider. Having a medical condition alone is not enough to make you eligible for accommodation under the Americans with Disabilities Act. Under the ADA, as amended by ADA Amendments Act of 2008, an individual with a disability is a person with a physical or mental impairment that substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such impairment. A substantial limitation is defined as an impairment that prevents the performance of one major life activity that the average person in the general population can perform or a significant restriction as to the condition, manner, or duration under which an individual can perform a particular major life activity as compared to the average person in the general population.

The Americans with Disabilities Act, as amended by ADA Amendments Act of 2008, requires that the University keep medical information confidential. However, the law permits certain individuals to be informed of your condition as needed. These persons can include your manager(s) or supervisor(s), human resource personnel, first aid and safety personnel, personnel investigating compliance with the ADA and other persons with a need to know. The law does not prohibit you from voluntarily discussing your condition or medical information about yourself.

I, _____ (print name), am requesting that the University provide me with a reasonable accommodation pursuant to the Americans with Disabilities Act. I understand that I must be able to perform the essential functions of my job with or without accommodation.

Requestors Information			
Mailing Address	**Street:**		
	City, State & Zip:		
Position Title			
Department Name			
Eid / 800#		**Email Address**	
Work Phone		**Home/Cell Phone**	
Immediate Supervisor		**Supervisor's Phone**	
Briefly, describe your work duties			

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Please answer the following questions:

(1) What is your medical condition? (specify medical condition(s) which affects your job and for which you are requesting accommodation)

_____

(2) Is this condition permanent? ☐ **Yes** ☐ **No**

If your condition is not permanent, what is the expected duration? ____/____/____ **(date)**

(3) To manage your condition, do you use medication or other aids? ☐ **Yes** ☐ **No**

If "yes," please describe:

_____

(4) Do the medications or aids you use have side effects which affect your ability to do your job?

☐ **Yes** ☐ **No** **If "yes" please explain:**

_____

(5) What specific work-related duties are impacted by your medical condition?

_____

(6) Are there any major life activities that you are unable to perform or are severely restricted in performing due to your medical condition? ☐ **Yes** ☐ **No** **If "yes," please explain:**

_____

(7) What reasonable accommodation(s) are you requesting to enable you to perform the essential functions of your job? Please be specific.

_____

Employee Signature: _____ **Date:** ____/____/____

Please ensure to complete all pages of the Employee Request for Accommodations Form, this entails an Authorization of Release of Medical Information on the following page.

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ADA: Authorization of Release of Medical Information

You are hereby authorized to provide The University of Texas at El Paso with information regarding your findings on the present condition of my health as it relates to my request for accommodation under the Americans with Disabilities Act (ADA).

_____ ____/____/____

Employee Signature **Date**

This grant of temporary authority shall begin on ____/____/____, and shall remain effective until terminated by the undersigned.

Primary Care Physician Information	
Name	
Phone Number	
Mailing Address	**Street:**
	City, State & Zip:

Upon completing the entire form, please print and submit to:

The Equal Opportunity Office
500 W. University Avenue
Kelly Hall, Room 302
(915) 747-5662
Or by email: eoaa@utep.edu

The University's full policy regarding Accommodations for individuals with Disabilities is available in the University's Handbook of Operating Procedures, Section VI, Chapter 2.

Office Use Only		
Office Stamp Date		**Comments:**
Received by	_____	