

**REASONABLE ACCOMMODATION REQUEST FORM**

College

**This form must be completed by the individual requesting a reasonable accommodation and submitted to the Office of Human Resources. Information regarding requests for reasonable accommodations is confidential and will be shared only with appropriate personnel as necessary. In the case of an accommodation based on a status as a victim of domestic violence, sex offense or stalking, your request will be shared with the Title IX Coordinator. For accommodations relating to disability or pregnancy, childbirth or related medical condition, you may be required to complete a Health Care Provider Accommodation Assessment Form to support your request. Your cooperation is essential in order to ensure a productive, interactive process with the goal of finding an acceptable accommodation. You are protected from retaliation for making this request.**

**EMPLOYEE:**

Name  Empl. ID

Contract Title  Department

Phones: Work  Home  Cell

E-mail

**JOB APPLICANT:**

Name  Job ID#

Phones: Work  Home  Cell

E-mail

**HOW WOULD YOU LIKE FOR OUR OFFICE TO CONTACT YOU?**

Work Phone    Home Phone    Cell Phone    E-mail

**BASIS FOR REASONABLE ACCOMMODATION REQUEST:**

Disability                       Pregnancy, childbirth or a related medical condition

Religion                             Status as a Victim of Domestic Violence, Sex Offense, or Stalking

**DESCRIBE YOUR ACCOMMODATION REQUEST. PLEASE BE SPECIFIC. INCLUDE HOW THE ACCOMMODATION REQUEST WILL ASSIST YOU IN PERFORMING THE ESSENTIAL FUNCTIONS OF THE JOB.**

***Attach supporting documentation, as necessary.***

**FOR DISABILITY ACCOMMODATION REQUESTS**

1. What is the nature of your disability?

- Mobility Impairment       Hearing       Mental / Emotional       Cognitive
- Visual       Speech       Learning       Chronic Illness

Other

2. Is this a permanent or temporary condition? If temporary, please indicate the duration of the condition. How long do you anticipate the need for an accommodation?

3. What limitations caused by your condition are you currently experiencing?

4. What, if any, assistive technology or equipment are you requesting?

5. How will the requested accommodation(s) assist you?

*I understand that, by making this request, I am authorizing CUNY personnel to discuss information regarding my request with my immediate supervisor and other CUNY employees for the purpose of assessing whether my request is reasonable and does not impose an undue hardship on CUNY. I understand that all information regarding my request, including medical documentation and the reason(s) for granting or denying accommodations, will be kept confidential. I also understand that if and when reasonable accommodations have been provided to me, I will be held to CUNY's performance and conduct standards.*

Signature \_\_\_\_\_

Date \_\_\_\_\_

**RECEIVED BY (This form must be signed and dated by the Director of Human Resources or Designee)**

Name

Signature \_\_\_\_\_

Date \_\_\_\_\_