University of Montevallo
ADA Reasonable Accommodation Request Form

To be completed and returned to the Office of Human Resources
Lyman House
Station 6055
HR@montevallo.edu

Name:

M#	**Work Phone:**

Cell Phone:	**Email:**

Position (Title/Rank):	**Department:**

Supervisor/Department Head:

NATURE OF THE QUALIFYING DISABILITY: (Please describe the nature, extent, and duration of your disability.)

REQUESTED/SUGGESTED ACCOMMODATION: (Please describe the accommodations you believe are needed to enable you to perform the essential functions of this job.)

PHYSICIAN CONTACT INFORMATION (Employees only) (Please provide name, address, telephone and fax numbers. The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations.)

I authorize the release of necessary confidential medical information regarding my disability to relevant hiring managers as deemed necessary by Human Resources. I also attest to the fact that a copy of the position description has been given to me for review and reference.

Signature: ____

Date: ____

[To signatory: Decisions regarding accommodations will be made within 12 calendar days or as promptly as possible following receipt of complete information. Delays may be incurred due to communication with health care providers.]

For questions or assistance with this form, please contact:

Barbara Forrest

Director of Human Resources & Risk Management

University of Montevallo

205-665-6055

forrestb@montevallo.edu