[Your company name and logo]

**ADA Reasonable Accommodation Request Form**

The Americans with Disabilities Act (ADA) requires employers to provide reasonable accommodations to qualified individuals with disabilities, unless it would cause undue hardship. A reasonable accommodation is any change in the work environment or in the way a job is performed that enables a person with a disability to enjoy equal employment opportunities.

If you require an accommodation, please complete this form and return it to Human Resources (HR). You may also need to provide additional medical documentation about your disability and your need for accommodation.

**Employee Information**

|  |  |
| --- | --- |
| **Name** |  |
| **Job Title**  |  |
| **Department** |  |
| **Contact Information** |  |
| **Supervisor’s Name** |  |

**Accommodation Request**

**1. Description of disability**

Please describe the nature of your disability and how it affects your ability to perform your job duties.

**2. Specific accommodation requested**

Have you engaged in an interactive dialogue with your supervisor or HR representative to discuss your accommodation needs?

[ ]  Yes

[ ]  No

If yes, please provide a brief summary of the interactive dialogue:

If no, please describe the specific accommodation you are requesting:

 [](http://aihr.com)

[aihr.com](https://www.aihr.com/)

**3. Requested accommodation**

Please select the type of accommodation you are requesting (check all that apply):

* Flexible work schedule (e.g., adjusted start/end times, telecommuting)
* Modified job duties or job restructuring
* Assistive technology or equipment
* Physical modifications to the workspace
* Other (please specify):

**4. How will this accommodation assist you?**

Please explain how the requested accommodation will assist you in performing the essential functions of your job or enjoying the same benefits and privileges of employment as are enjoyed by employees without disabilities:

**Employee name:**

**Employee signature:**

**Date:**

I confirm that the information provided in this request is accurate to the best of my knowledge. I understand that the company may need to share this information with relevant parties involved in the accommodation process.

**For HR Department Use Only**

Received by:

Date:

**Decision**:

[ ]  Approved

[ ]  Denied

If denied, reason for denial:

Date of Implementation (if approved):

Signature:

Date:

*Please note: All medical information received in connection with this request will be treated as confidential as required by the ADA and will be shared only on a need-to-know basis.*

  [](http://aihr.com)

[aihr.com](https://www.aihr.com/)

