Disability Accommodation Review Form



Name of employee requesting accommodation:

_____Please print

Name of individual completing this form:

_____Please print

Date of initial request: _____/_____/_____ Date of review: _____/_____/_____

Accommodation requested:

_____
 _____
_____

Reason for accommodation:

_____

Essential function(s) affected:

_____
_____
_____

Is accommodation requested unreasonable? □ YES □ NO

Will the accommodation pose an undo hardship on the organization? □ YES □ NO

If no to both will the accommodation be provided? □ YES □ NO

If no, why not:

_____

If yes to either of the above what is the suggested alternative accommodation:

_____
_____

If an accommodation is offered when will it begin and for how long will it be provided?

Start date: _____/_____/_____ End date: _____/_____/_____

Date scheduled for follow up: _____/_____/_____

Name of reviewer:_____Please print

Signature of reviewer: _____
Date: _____/_____/_____