UGA Reasonable Accommodations Request Form

The University of Georgia (UGA) provides reasonable accommodations for employees with ADA defined disabilities. A reasonable accommodation is an accommodation that enables the employee to perform the essential functions of their position, is medically necessary, and does not create an undue hardship to the institution. Employees who are requesting reasonable accommodation must complete and submit this request form along with supporting documentation to the Absence Management team in University Human Resources at hrweb@uga.edu.

- A confidential interactive discussion with Human Resources is encouraged for employees who are seeking reasonable accommodations.
- The campus accommodation process is meant to address accommodations directly related to the employee (one's self) and their job functions. If you are seeking an accommodation related to the care of others, please refer to employee leave options (including Family Medical Leave Act (FMLA).
- If more information is needed, the University may require that you authorize your health care provider to confirm your disability and/or the need for the requested accommodation.
- It is your responsibility to ensure that your health care provider statement or other supporting documentation is returned to Absence Management.
- You are not required to disclose to your immediate supervisor the medical basis for a requested accommodation. Medical records are confidential and maintained in University Human Resources only.

To request assistance with the process or form, please contact University Human Resources (706) 542-2222 or at hrweb@uga.edu.

EMPLOYEE INFORMATION		
Employee Name:	Employee ID #:	
Employee Job Title:	Employee Department:	
Home Phone Number:	Cell Phone Number:	E-mail:
Supervisor Name:	Supervisor E-mail:	
ACCOMMODATION TIMEFRAME		
This is a *(choose one)*: ☐New request for accommodations ☐Request for an extension and/or alteration of existing accommodations* Physician confirmation may be required.		
Anticipated Begin Date of accommodations:	Expected end date of accommodations:	
NATURE OF THE QUALIFYING DISABILITY: What physical or mental impairment have you been diagnosed with by your physician(s) that require ADA accommodations? _____		

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REQUESTED/SUGGESTED ACCOMMODATION: What Specific accommodation(s) are you requesting? Please select from the options below:
☐Modification of job duties. Please describe: Duration requested: / / until / /
☐Modification of work schedule (telework, flexible scheduling, reduction of hours, etc.). Please describe: Duration requested: / / until / /
☐Modification of physical environment (i.e. alternative on-site work location). Please describe: Duration requested: / / until / /
☐Leave of absence or intermittent leave use: Please describe and complete a copy of departmental leave form: Duration requested: / / until / /
☐Assistive equipment. Please describe equipment you are requesting that the Institution provide:
☐Facilities modification (e.g., doors widened, ramps installed). Please describe:
☐Interpreter (Sign Language), reader, or real time captioning. Please describe:
☐Classroom Reassignment. Please describe (include current and desired assignment):
☐Other Accommodation. Please describe the accommodations you believe are needed to enable you to perform the essential functions:
JOB DUTIES, ESSENTIAL FUNCTIONS, AND ACCESSIBILITY
Please provide a description of your current primary job duties, which of those duties you perceive could be performed with accommodations, and how. (Please attach additional pages if needed) Essential functions as outlined in the employee's official position description and/or from the employee's supervisor will also be reviewed. If more specific information is needed to respond to your request, a Job Analysis for your position may be prepared.
JUSTIFICATION NARRATIVE
Please describe how the accommodation(s) requested above will allow you to perform the essential functions of your position (attach separate sheet if necessary):

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HEALTH STATEMENT AND INFORMATION

☐ Health Care Provider Statement (Provider documentation of accommodation requirement or work arrangement needed)

☐ Other Supporting Documentation (Record of diagnosis or other supporting documents that meets public health emergency guidance)

PHYSICIAN CONTACT INFORMATION: The physician may receive communication from the institution's HR department requesting information on your impairment/disability and recommendations for accommodations.

Physician's Name: Physician's Telephone #: Physician's Fax #:	Physician's Email Address: Physician's Address:

EMPLOYEE AUTHORIZATION

☐I authorize a representation of the UGA Faculty & Staff Relations Office to communicate directly with my health-care provider for confirmation of the impairment and clarification regarding the need for an accommodation.

Employee Signature: _____ Date: _____

EMPLOYEE CERTIFICATION

I certify that the above information is accurate and complete. I understand that I must contact the HR Faculty & Staff Relations Office regarding any changes or updates to this request as submitted.

Employee Signature: _____ Date: _____

UNIVERSITY HUMAN RESOURCES USE ONLY

Required documentation (if applicable) received from employee: No ☐ Yes ☐ Received on date: _____

Accommodations Decision: ☐ Approved ☐ Denied ☐ Modified as outlined below:

Name of University Representative:

Signature of University Representative: