HARVARD UNIVERSITY
Office of the Assistant to the President for Institutional Diversity and Equity
University Disability Services

Suite 727W, Richard A. and Susan F. Smith Campus Center
1350 Massachusetts Avenue, Cambridge, MA 02138
Telephone (617) 495-1859 Fax (617) 495-8520
disabilityservices@harvard.edu http://accessibility.harvard.edu/

CONFIDENTIAL
Reasonable Accommodation Request Form

The purpose of this form is to initiate the reasonable accommodation interactive process and assist Harvard University in determining whether, or to what extent, a reasonable accommodation is necessary for an employee with a disability to perform one or more essential functions of his or her job safely and effectively. This form is to be completed and will reside with your accommodation coordinator (Human Resources or University Disability Services) and will be treated confidentially, with information shared only on a strict need-to-know basis.

Employees should return the completed and signed Reasonable Accommodation Request form to their accommodation coordinator (if University Disability Services please see contact information above).

To be completed by the employee requesting accommodation:

Affiliation/School:	Department/Unit:
Employee Name:	Work Telephone:
Job Title:	Preferred Telephone:
Work Address:	Preferred Email:
Manager:	Telephone:
Other Departmental Administrator(s) (if applicable):	Telephone:
Human Resources Officer/Representative:	Telephone:

The accommodation requested is: _____

_____

I,_____ give Harvard University permission to explore possible eligibility and reasonable accommodations under the Americans with Disabilities Act and the ADA Amendments Act (any applicable related laws).

I understand that I am responsible for providing medical documentation from my health care provider(s) which substantiates my functional limitations and expected duration as related to performing the essential duties of my job.

I further understand that I may be required to complete and sign a release of information giving University Disability Services permission to consult with my health care professional(s) as necessary in order to determine that I am a employee with a disability, to seek clarification regarding any functional limitations resulting from my condition(s), and to assist in the exploration of possible reasonable accommodations.

_____

Date Employee's Signature

This document is available in alternate format upon request.

01/25/2017