OHIO UNIVERSITY

University Equity and Civil Rights Compliance, Equal Opportunity & Accessibility
006 Lindley Hall
Athens, OH 45701
Phone: 740.593.9140
Fax: 740.593.9168

Faculty & Staff Reasonable Accommodation (ADA) Intake Form

(Please Note: The information provided will be treated as confidential.)

Date: ______________________________ PID# (Employee Number): ____________________

Name: ____

Home/Mobile Phone: ______________________ Is it OK to leave a message for you at this number? Y / N

Work Phone: ______________________ Is it OK to leave a message for you at this number? Y / N

Email Address: ______________________ Is it OK to email you? Y / N

Mailing Address: ____

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Position Description:

- ☐ Administrative
- ☐ Classified
- ☐ Student
- ☐ Bargaining Unit
- ☐ Faculty
- ☐ External Provider

Department: ______________________ Position Title: ______________________

Supervisor's Name and Title: ____

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Supervisor's Phone: ____

Current Work Status (i.e., F/T, P/T, returning to work, etc.): ____________________

How were you referred? ____

Current Work Related Concerns:

Describe the physical or mental impairment, illness, condition or disease that is impacting you in a way that negatively affects your work and is the reason for a reasonable accommodation request within the scope provided under The Americans With Disabilities Act Of 1990, As Amended in 2008.

Please place an "X" next to those activities listed below that have been significantly affected by what you are currently experiencing as a result of the physical or mental impairment, illness, condition or disease currently being experienced.

☐ Walking ☐ Standing ☐ Sitting ☐ Speaking ☐ Breathing ☐ Seeing ☐ Hearing

☐ Learning ☐ Manual Tasks ☐ Lifting

☐ Work Environment Sensitivity (select all that apply): ☐ Functional ☐ Psychosocial

☐ Auto-immune Sensitivities

☐ Other (Please describe)

Please describe how your condition limits your ability to perform the essential functions of your position.

Describe any special methods, skills or procedures that would enhance your abilities to better perform one or more of the essential functions of your job.

If your condition is episodic or in remission, please identify and detail the nature, frequency, severity and duration of anticipated future episodes.

What would be helpful support during an episode or flare up?

Please provide the names and contact information of physicians, therapists, psychologists or other health care providers who have information or documentation concerning your physical or mental impairment, illness, condition or disease in relationship to your need for reasonable accommodation (s).

Is/are your physical or mental impairment, illness, condition or disease (s) acute or chronic?
☐ acute ☐ chronic If acute, how long do you anticipate the impairment(s) will last?

Have you had an opportunity to visit with your supervisor about the issues you identified above?
☐ Yes ☐ No If yes, when?

How? Did you communicate orally or in writing?

Was the response helpful? ☐Yes ☐ No If yes, what about the response was most helpful?

If no, what was missing?

What one thing would you like us to know that has not been shared?

Our office is committed to offering innovative support and strategic partnerships that are individually designed. We are dedicated to ensuring that the talents and competencies of those we serve are positioned such that they are maximized while the physical or mental impairment, illness, condition or disease is minimized.

(For Office Use Only)

Case Notes: