Northeastern
Human Resources Management

Accommodation Request Form

Northeastern University is committed to equal opportunity in all aspects of employment for qualified disabled individuals. The purpose of this form is to assist in determining whether, or to what extent, a reasonable accommodation is necessary for an individual with a disability to be considered for a job, to gain access to the workplace, to access benefits and privileges of employment or to perform one or more essential functions of his or her job.

Check list : Please complete the following

☐ Via employee self-service file your "Self-Identification of Disability," http://myneu.neu.edu/ or you may follow the path:

myNEU > Service and Links > Employee Self Service > Personal Information > Disability Status

☐ Accommodation Request Form

In order to fully evaluate your request for accommodation your "self-identification" and this form must be completed and submitted to Human Resource Management.

Northeastern University
ADA, Human Resource Management
716 Columbus Avenue, Suite 250
Boston, MA 02120
Fax: 617-373-7610
Email: hrm_ada@northeastern.edu

Employee Information:

Name: _____

Department/Unit _____ Position/Title: _____

Employment Status: ☐ FT ☐ PT ☐ Temporary ☐ Faculty ☐ Staff

Phone # (Work): _____

Phone # (Home/Cell): _____ Email Address: _____

Mailing Address: _____

_____

_____

Supervisor: _____ Phone #: _____

Work Schedule/Shift: _____

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Medical Condition Information:

1. Please indicate the nature of your disability:

☐ Visual Impairment	☐ Nervous System/Neurological Disorder
☐ Hearing Impairment	☐ Mental/Psychological Impairment
☐ Mobility Impairment	☐ Learning Disability
☐ Respiratory Impairment	☐ Other (Please Describe)
☐ Speech Impairment	

2. What is your medical condition(s):

_____

_____

3. Is your medical condition:

☐ Temporary (If so, how long is it expected to last?) _____

☐ Permanent _____

☐ Recurring (if so, how long is it expected to last?) _____

4. Please briefly describe any limitations or restrictions caused by your medical condition:

_____

_____

_____

_____

5. Please list any accommodation(s) or service(s) related to your medical condition that would help you be considered for a job, to gain access to the workplace, to access benefits and privileges of employment, or to perform the essential functions of your current job:

_____

_____

_____

_____

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6. Are you currently receiving any accommodation(s)? If so, please describe the accommodation(s).

_____

_____

_____

_____

_____
NAME

_____ _____
SIGNATURE DATE:

Note: *Accommodations are provided on a case-by-case basis in accordance with the Americans with Disabilities Act, as amended in 2008. To qualify for an accommodation, the employee must have a current medical condition that substantially limits a major life activity. Also, the accommodation must be necessary and reasonable to enable the employee to perform the essential functions of his/her job. A diagnosis, in and of itself, does not automatically qualify an employee for an accommodation.*