**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.

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| **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 the Office of Institutional Diversity and Inclusion.* ***Fax:******617-373-4146.*** |

**Employee Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | | |  | |
| Department/Unit: | |  | | Position/Title: |  |
| Employment Status:  FT  PT  Temporary  Faculty  Staff | | | | | |
| Phone # (Work): | | |  |
| Phone # (Home/Cell): | | |  | Email Address: |  |
| Mailing Address: | | |  | | |
|  | | | | | |
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| --- | --- | --- | --- |
| Supervisor: |  | Phone #: |  |
| Work Schedule/Shift: |  | | |

**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 |  |

1. 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?) |  |

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

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

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| --- | --- | --- |
| 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.*