

Reasonable Accommodation Request Form

Instructions

Please submit forms to: Human Resources Illinois Institute of Technology, 3300 S. Federal Street Chicago, IL 60616
Fax: 312.567.3450. **Questions:** 312.567.3318 or hr@iit.edu

Supporting Materials: Please ensure that the following materials accompany the submission of this form:

- Signed release form Medical documentation from attending physician
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Personal Information

Today's Date (mm/dd/yyyy): _____ / _____ / _____

Last Name: _____ First Name: _____

Sex: Male Female

Department: _____ Job Title: _____

Home Address: _____ Apt. #: _____

City, State, ZIP: _____ Home Phone: () _____ - _____

Campus Address: _____ E-mail: _____

Campus Phone: () _____ - _____ Fax: () _____ - _____

Disability Information

Please describe your disability, including the expected duration of the impairment (*attach sheet of paper for additional space*):

Please describe the job-related tasks you have difficulty performing due to you disability (*attach sheet of paper for additional space*):

Please describe the accommodation(s) you are requesting and indicate how the accommodation(s) will enable you to perform the job tasks (*attach sheet of paper for additional space*):

Disability Information Release Form

Instructions

Please list all physicians and/or clinicians whose documentation you have provided.

Please submit form to: Illinois Institute of Technology Department of Human Resources, 3300 S. Federal Street
Chicago, IL 60616, Fax: 312.567.3450. **Questions:** 312.567.3318 or hr@iit.edu

Physician/Clinician #1

I, _____ (Employee's name), hereby give permission for
_____ (Physician/Clinician) to release any pertinent information on
_____ (Employee's name) to the Human Resources Department at
Illinois Institute of Technology. I understand that any information received will be kept confidential and will be released only to
the extent necessary to obtain accommodations.

Employee Signature: _____ Date (mm/dd/yyyy): _____

Witness Signature: _____ Date (mm/dd/yyyy): _____

Physician/Clinician #2

I, _____ (Employee's name), hereby give permission for
_____ (Physician/Clinician) to release any pertinent information on
_____ (Employee's name) to the Human Resources Department at
Illinois Institute of Technology. I understand that any information received will be kept confidential and will be released only to
the extent necessary to obtain accommodations.

Employee Signature: _____ Date (mm/dd/yyyy): _____

Witness Signature: _____ Date (mm/dd/yyyy): _____

Physician/Clinician #3

I, _____ (Employee's name), hereby give permission for
_____ (Physician/Clinician) to release any pertinent information on
_____ (Employee's name) to the Human Resources Department at
Illinois Institute of Technology. I understand that any information received will be kept confidential and will be released only to the
extent necessary to obtain accommodations.

Employee Signature: _____ Date (mm/dd/yyyy): _____

Witness Signature: _____ Date (mm/dd/yyyy): _____