UHCL | Human Resources
Administration and Finance

Request for Workplace Accommodation Form

Employee Requesting Accommodation: _____ Date: _____

Employee ID: _____ Phone: _____

Job Title: _____ Department: _____

Direct Supervisor:_____ Supv. Title: _____

1. Describe your disability/condition, including the expected duration of the impairment and whether it will change with time.
   _____
   _____
   _____

2. Describe the job functions(s) you are having difficulty performing and/or the employment benefits you are having difficulty accessing:
   _____
   _____
   _____

3. How is your condition impacting your ability to complete the duties listed in #2 above?
   _____
   _____
   _____

4. Describe the specific accommodation(s) you are requesting and how these will help you perform your job duties:
   _____
   _____
   _____

5. Additional comments:
   _____
   _____
   _____

Please refer to 02.E.09 System Administrative Memorandum (S.A.M.) for Reasonable Workplace Accommodations for Employees with Disabilities. Upon request, additional copies of the policy can be furnished.

Medical Documentation to support accommodation request attached: ☐ **YES** ☐ **NO**

I understand that the Office of Human Resources will contact and exchange information with my supervisor, my licensed health care practitioner, and/or any other individual deemed appropriate, as necessary, to determine my ability to perform my essential job functions, to work in the job environment, to work a particular job schedule, and to determine possible accommodations.

Employee Signature _____ **Date** _____

FINAL APPROVAL IS SUBJECT TO INSTITUTIONAL REVIEW

Return this form to: Office of Human Resources | Fax: 281-283-2158