EQUAL EMPLOYMENT OPPORTUNITY AND TITLE IX COMPLIANCE
AMERICANS WITH DISABILITIES ACT (“ADA”)
REASONABLE ACCOMMODATIONS REQUEST FORM
(ACD-RA FORM 1)

Today’s Date: ________________________________

Employee’s Name: _________________________________________

Employee ID No.: ________________ Date of Hire: ________________

Employee’s Date of Birth: ____________________________________

Employee’s Home or Personal Telephone Number: ________________

Employee’s Personal Email Address: _____________________________

Employee’s Home Address: ____________________________________

________________________________________________________________

Employee’s Position: _________________________________________

Employee’s Current School/Office: ________________________________

Immediate Supervisor: _________________________________________

Immediate Supervisor’s Title: _________________________________

Immediate Supervisor’s Phone Number: __________________________

Please answer the following questions as fully as possible. If you need more space please write your answers on a separate sheet of paper.
1. Please identify your medical condition(s)/impairment(s) for which you are seeking an accommodation:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Under the ADA, to be eligible for an accommodation your medical condition(s)/impairment(s) must **substantially limit** one or more major life activities, including, but not limited to, walking, breathing, speaking, seeing, hearing, sitting, standing, lifting, etc.

2. How does your medical condition(s) or impairment(s) limit any major life activity?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

3. Please state how long your medical condition(s)/impairment(s) is expected to last:
____________________________________________________________________

4. What **specific** job duties are affected by your medical condition(s)/impairment(s)?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

5. What types of accommodations do you believe would enable you to perform the essential functions of your job?
____________________________________________________________________
____________________________________________________________________
6. In order to effectively evaluate your eligibility under the ADA, we will need to request information from your health care providers regarding your medical condition(s)/impairment(s). Please list the name and contact information for each provider who has knowledge of you medical condition(s)/impairment(s).

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Hospital/Clinic Name</th>
<th>Address</th>
<th>Phone Number</th>
<th>Fax Number</th>
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7. Have you previously requested Reasonable Accommodations? Yes __ No __

8. If you responded “yes” to Question 7, please state whether you were granted accommodations and, if so, the date those accommodates were granted:
__________________________________________________________________

9. If you responded “yes” to Question 8, please state what accommodations were granted:
__________________________________________________________________

10. If you responded “yes” to Question 7, has your condition changed since you previously made the request for accommodations? Yes __ No __

11. If you responded “yes” to Question 10, please state how your condition has changed:
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

__________________________________________________________________

ADA Request Form 3 of 4
If you have any additional attached pages, please sign and date them. The number of supplemental pages attached to this form is ____ (If there are no attached supplemental pages please write “0”).

The foregoing request contains all of the relevant information that is accurate, factual and complete. Any incomplete, misleading or false information submitted as a part of this request may be cause for denial of a request for an accommodation.

____________________  ____________________
Employee Signature          Date

Please return this form, the Reasonable Accommodations Request Form, the Authorization for Release of Employee Medical Documentation and, any supplemental pages to:

   EEO and Title IX Compliance
   Attn: EEO Manager
   200 E. North Avenue, Room 208
   Baltimore, Maryland 21202
   410.396.8542 (phone)
   410.396.2955 (facsimile)