

**University Staff or Academic Employee:**

The University of Washington provides reasonable accommodations for employees with sensory, mental or physical disabilities. A reasonable accommodation is an accommodation that enables the employee to perform the essential functions of their position, is medically necessary, and does not create an undue hardship. For detailed information on the accommodation request process, please see the “Disability Accommodation Request Process for Employees and Appointees” on the University Human Resources website at:

<http://www.washington.edu/admin/hr/polproc/accommodation/accomrequestproc.html>

Please complete this request form and return it to the Disability Services Office. **You are not required to disclose to your immediate supervisor the medical basis for a requested accommodation.** If more information is needed, the University may request that you ask your health care provider to confirm your disability and/or the need for the requested accommodation. **It is your responsibility to see that your health care provider returns the “Health Care Provider Statement” (UoW 1206) to the Disability Services Office.** If more specific information is needed to respond to your request, a Job Analysis for your position may be prepared. A completed copy of the Job Analysis will be shared with you and your health care provider.

If you are **only** requesting an ergonomic workstation evaluation, you do not need to complete this form. Please contact Environmental Health & Safety at 206-543-7262 or visit their website at [www.ehs.washington.edu](http://www.ehs.washington.edu) to learn more about ergonomic resources.

Medical records are confidential and are maintained in the Academic or Staff Human Resource offices and/or Disability Services Office, **not** in departmental files.

**University Staff:** professional, classified non-union and contract-classified staff, temporary staff [monthly or hourly paid], hourly paid student employees, and all other non-academic employees.

If you have questions regarding accommodation, please contact your Human Resource Consultant or the Disability Services Office. A list of the Human Resource Operations offices is provided below.

<b>HUMAN RESOURCES OPERATIONS OFFICES</b>			
<b>CAMPUS HR OPERATIONS</b>		<b>MEDICAL CENTERS HR OPERATIONS</b>	
206-543-2354 (v)	HMC	206-744-9220 (v)	UWMC 206-598-6116 (v)
206-685-0636 (fax)		206-744-9955 (fax)	206-598-4610 (fax)
BOX 359532		BOX 359715	BOX 356054

**Academic Personnel:** faculty, librarians, fellows, residents, graduate student service appointees or other academic personnel

If you have questions regarding accommodation, please contact the Disability Services Office, or one of the resources below:

<b>CONTACTS</b>	
<b>General Information:</b>	Disability Services Office Box 354560 206-543-6450 (v); 206-543-6452 (tty); 206-685-7264 (fax)
<b>Librarians:</b>	Senior Associate Dean of University Libraries Box 352900 206-685-1978 (v); 206-685-8727 (fax)
<b>Residents and Fellows in School of Medicine:</b>	Graduate Medical Education Office Box 358047 206-543-6806 (v)
<b>Faculty, graduate students and all other academic employees:</b>	Academic Human Resources Box 351270 206-543-5630 (v)

**To request this form or other accommodation related materials in an alternate format, or to request an interpreter or other accommodation during the disability accommodation process, please contact the Disability Services Office, 206-543-6450 (voice), 206-543-6452 (tty), or [dso@u.washington.edu](mailto:dso@u.washington.edu).**

**ACCOMMODATION REQUEST FOR DISABILITY OR SERIOUS MEDICAL CONDITION**

**EMPLOYEE:** To request accommodation, please **print, complete** and **sign** this form. **Do not include diagnosis or medical reason.** Please **make a copy** of the form for your records. Return the completed form to the **Disability Services Office, 1100 NE Campus Parkway, Suite 836, Seattle, WA 98195 (USPS) or Box 354560 (campus mail) or FAX: 206-685-7264.**

**RECEIVING DEPARTMENT:** For questions regarding staff requests, contact your Human Resources Consultant. For questions regarding requests from academic personnel, contact: **Faculty** –appropriate Dean’s Office; **Librarians** – Senior Associate Dean of University Libraries; **Residents/Fellows in the School of Medicine** – Graduate Medical Education Office; **All Others** – Disability Service Office.

SECTION I – EMPLOYEE INFORMATION					
Last Name:	First Name:	Middle:	Email:	Employee ID Number:	
Department:	Box Number:	Job Title:		Phone:	Work Location/Building:
Name of Immediate Supervisor:	Supervisor’s Email:		Supervisor’s Phone:	Supervisor’s Box Number:	
SECTION II – REQUEST INFORMATION					
Contact the Disability Services Office, <a href="mailto:dso@u.washington.edu">dso@u.washington.edu</a> , Box 354560, 206-543-6450 (v), 206-543-6452 (tty) if you have questions about any of the accommodations listed below.					
<input type="checkbox"/> <b>Assistive equipment.</b> Please describe equipment you are requesting that the University provide:					
<input type="checkbox"/> <b>Facilities modification (e.g., doors widened, ramps installed).</b> Please describe:					
<input type="checkbox"/> <b>Interpreter (Sign Language), reader, or real time captioning.</b>					
<input type="checkbox"/> <b>Classroom Reassignment.</b> Please describe (include current and desired assignment):					
<input type="checkbox"/> <b>Disability Parking or Transportation.</b> <input type="checkbox"/> <b>Disability parking permit.</b> If you have WA State disability parking tags, indicate tag number . _____ and expiration date _____ <input type="checkbox"/> <b>Alternate transportation (Dial-A-Ride)</b> Duration requested (check one): <input type="checkbox"/> Short term (6-8 weeks) <input type="checkbox"/> Long term					
If change is significant or if you have questions: <b>staff employees:</b> contact your Human Resources Consultant. <b>Academic personnel:</b> contact the office specified on the cover page.					
<input type="checkbox"/> <b>Leave of absence or intermittent leave use:</b> Please complete a copy of departmental leave form.  Duration requested:    /    /    until    /    /					
<input type="checkbox"/> <b>Reduction in work schedule:</b> Please describe:  Duration requested:    /    /    until    /    /					
<input type="checkbox"/> <b>Modification of job duties:</b> Please describe:  Duration requested:    /    /    until    /    /					
<input type="checkbox"/> <b>Other change in work schedule.</b> Please describe:					
<input type="checkbox"/> <b>Other accommodation.</b> Please describe:					
<input type="checkbox"/> <b>If this request is due to an on-the-job injury or illness, please complete the following:</b>  Date of injury or onset of illness:    /    / Have you filed a claim with the Department of Labor & Industries? <input type="checkbox"/> Yes <input type="checkbox"/> No* *If no, contact your health care provider to initiate workers’ compensation claim.					
<b>Please describe how the accommodation(s) requested above will allow you to perform the essential functions of your position</b> (attach separate sheet if necessary):					
Employee Signature: _____			Date: _____ Home Phone: _____		