Applicant, Faculty & Staff Request for Disability Accommodation Intake Form

(Please Note: The information provided will be treated as confidential.)

Department of Human Resources
Administration Center (AC), Room 113
2121 Euclid Avenue
Cleveland, Ohio 44115
Phone: 216-687-3636
Fax: 216-687-9334

All individuals employed or applying for employment at Cleveland State University, believing they are an individual with a disability, and would like to request reasonable accommodation(s) under the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008 (ADAAA), must meet with the Department of Human Resources.

Please complete all applicable information and return to Human Resources

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Date: _____ ID# (Employee ID): _____

Name: _____

Home/Mobile Phone: _____ Is it OK to leave a message for you at this number? Y / N

Work Phone: _____ Is it OK to leave a message for you at this number? Y / N

Email Address: _____ Is it OK to email you? Y / N

Mailing Address: _____

_____

Position Description:

☐ Faculty
☐ Staff
☐ Applicant

☐ Bargaining Unit

Department: _____ Position Title: _____

Supervisor's Name and Title: _____

_____

Supervisor's Phone: _____

Current Work Status (i.e., F/T, P/T, returning to work, etc.): _____

Work Schedule/Shift: _____

Current Work Related Concerns:

(For current CSU employees only) Describe the **job duties** that are expected of you for which you are requesting accommodation.

Describe the **functional limitation(s) caused by your condition(s)** for which you are requesting accommodation.

Does your disability **substantially limit you in:** (please check all that apply)

☐ Walking ☐ Standing ☐ Sitting ☐ Speaking ☐ Breathing ☐ Seeing ☐ Hearing

☐ Learning ☐ Manual Tasks ☐ Lifting ☐ Reaching ☐ Sleeping ☐ Learning

☐ Concentrating ☐ Thinking ☐ Interacting with others

☐ Work Environment Sensitivity (select all that apply): ☐ Functional ☐ Psychosocial

☐ Auto-immune Sensitivities ☐ Other (Please describe):

Is/are your condition(s) temporary or permanent? ☐Temporary ☐Permanent

If temporary, how long do you anticipate the impairment(s) will last?

Please describe any **potential reasonable accommodations(s)** that would overcome the above limitations.

(For current CSU employees only) Please provide the names and contact information of health care providers who have information or documentation concerning your condition(s) related to your need for reasonable accommodation(s).

My signature attests to the accuracy of the above statements, to the best of my knowledge:

_____ _____

Signature Date

Our office is committed to offering innovative support and strategic partnerships that are individually designed. We are dedicated to ensuring that the talents and competencies of those we serve are positioned such that they are maximized while the physical or mental impairment, illness, condition or disease is minimized.

(For Office Use Only)

Case Notes: