UNIVERSITY OF GUAM
UNIBETSEDÅT GUAHAN

EEO/ADA & TITLE IX OFFICE

Employee Request for Disability Accommodation and Services

(To be completed by Employee)

Your Name: _____ Date: _____

Position: _____Administrator/Supervisor:_____

1. What is your disability? Please specify the date your disability commenced and its expected duration.

2. What is the reasonable accommodation(s) that you are requesting? Be as clear and specific as possible.

3. Please explain how the requested accommodation, aid or assistance measure will help you to perform your duties at the University of Guam (University).

4. Please explain if there are **other** accommodations, aids or assistance measures which may assist you to perform your responsibilities as an employee of the University.

5. Are there any elements of your position at the University that you cannot complete **without** the accommodation you are requesting? If so, please explain.

6. Are there any elements of your position at the University that you cannot complete **even with** the accommodation you are requesting?

T: +1 671.735.2244 F: +1 671.734.0430 TDD: +1 671.735.2243 E: eeo-ada@triton.uog.edu
W: www.uog.edu
Mailing Address: 303 University Drive UOG Station Mangilao, Guam 96913

I, _____, request that the above accommodations be provided to me as a qualified employee of the University of Guam (University) with a disability. I further understand that the University will reasonably accommodate individuals with disabilities, as defined by applicable law, if the individual is otherwise qualified to meet the fundamental requirements and aspects of the program of the University, without undue hardship to the University.

The information that I have provided is true, correct, and complete. I hereby authorize, _____, my treating physician and/or other related health care professional(s) to provide information regarding my condition to the University of Guam to assist in identifying and providing me with the accommodation(s) requested.

_____ _____

Signature of Employee **Date**

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Health Care Professional Section

(Please attach additional pages and supporting documents, if necessary.)

Employee's Name: _____

1. Please complete the Verification of Disability portion or note here if the employee is **not** a qualified person with a disability.

2. Please identify the specific diagnosis and description of the above-named employee's disability, to include the date the disability commenced and its expected duration.

3. What is the reasonable accommodation(s) that you are recommending? Be as clear and concise as possible.

4. Please explain how the requested accommodation, aid or assistance measure will be effective in enabling the employee to perform his/her duties at the University.

5. Please explain if there are **other** accommodations, aids or assistance measures that will enable the employee in performing his/her responsibilities as an employee of the University.

6. Are there any elements of the employee's position that he/she cannot complete **without** this accommodation? If so, please explain.

7. Are there any elements of the employee's position that he/she cannot complete **even with** this accommodation? If so, please explain

_____ _____
Name of Health Care Professional **Date**

_____ _____
Signature of Health Care Professional **Date**

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VERIFICATION OF DISABILITY

Please attach using official letterhead a statement that certifies the following:

1. Name of Employee ("individual") and Date of Birth

2. The nature of any physical or mental impairment experienced by the Individual.

3. How the impairment limits one or more of the individual's major life activities.

4. The onset and expected duration of the disability.

5. Recommendations regarding the type of assistance needed for the Individual to be employed in their position at the University.

The name of the professional providing the verification, title, contact information, and signature should also be noted.

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