UNIVERSITY OF GUAM
UNIBETSEDÅT GUAHAN

EEO/ADA & TITLE IX OFFICE

Request for Disability Accommodation and Services

Name: ____ Date: ___________________

Contact Information: ____

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.

4. Please explain if there are **other** accommodations, aids or assistance measures which may assist you.

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

6. Are there any elements 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
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I, ______________________________________, request that the above accommodations be provided to me as an individual with a disability, as defined by law and qualified to meet the fundamental requirements and aspects, without undue hardship.

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.

____ ________________________

Signature **Date**

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Physician's Disability Certification

This is a certification that the named individual below, was determined by a physician to have met the Americans with Disabilities Act (ADA) definition of an "individual with disability (ies)" in accordance with the ADA disability criteria below:

Name: ____

Date of Birth: ____

_____ Has a physical and/or mental impairment that substantially limits one or more of the major life activities of the individual.

_____ Has a record of such impairment; and/or

_____ Be regarded as having such an impairment.

PHYSICIAN USE ONLY

Disability ____

____Permanent ____Temporary ________________________________
(Length of Certification)

Name of Physician: ____

Address: ____

Contact Number(s): ____

Physician's Signature: ____ ____________
Date

Physician or Clinic Stamp: ____

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