Employee Information

Name:	Email:	Contact # ( )
Title:	Supervisor:	Contact # ( )

1.	What type of accommodation are you requesting?
2.	Please provide a brief description of your physical or mental impairment(s) that limit your ability to perform the job duties.
3.	Describe the specific action(s), changes, equipment or modifications that you are requesting as an accommodation. Be as specific as possible.
4.	Describe how the requested accommodation(s) will enable you to perform the duties of the position.
5.	Explain, if applicable, any resources you already have access to, or are aware of which would provide the accommodation(s) requested.

Acknowledgement

I give Williams College permission to explore options for a reasonable accommodations under the Americans with Disabilities Act (ADA) on my behalf. This may include speaking to college personnel and/or my health care professional. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements.

I understand that it will be my responsibility to provide documentation of my disability, for my request to be evaluated. I am also required to complete and submit the medical release and certification, in a timely manner to the Office of Institutional Diversity and Equity (OIDE). I further understand that the OIDE will evaluate and respond to me based upon the information that is provided by myself or my physician. I also attest that the information provided by me is true and correct to the best of my knowledge.

Employee's Signature:	Date: ____/____/_____

Employee Consent

I, _____, give my healthcare provider permission to release my medical
(Print Name)
information as it relates to my physical or mental impairment to the Office of Institutional Diversity and Equity.

Employee's Signature:	**Date: ____/____/_____**

Heath Care Provider Medical Certification

Please provide information to assist in the request for a reasonable accommodation for the above named individual.

1. Please list the physical or mental impairment(s) for which the employee is being treated.	2. Estimated length of impairment/condition?	3. Please provide treatment plan details and surgery date if applicable?	4. Restrictions?
(a)			
	Next Appointment: / /	Surgery Date: / /	Restrictions Expire: / /
(b)			
	Next Appointment: / /	Surgery Date: / /	Restrictions Expire: / /
Comments:			

(Physician's/Practitioner Name (Print)	**Degree/Specialty/Type of Practice**
Street Address, City, State, and Zip	**Phone ( )**
Physician's Signature:	**Date:**