SPC St. Petersburg College
HUMAN RESOURCES

ACCOMMODATION REQUEST FORM

The College is committed to equal opportunity in all aspects of employment. This form is intended to assist in determining whether, and to what extent, a reasonable accommodation is necessary and available for an employee with a disability to perform the essential functions of his or her job safely and effectively. The information you provide will be kept confidential consistent with state and federal laws. Information may be shared with supervisors and managers to the extent necessary to engage in the interactive process regarding necessary accommodations. Health and safety personnel may be informed if the condition might require emergency treatment. Government and College officials investigating compliance with applicable laws might be informed on the information disclosed.

EMPLOYEE INFORMATION:

Name: _____ Department: _____

Position/Title: _____ Employee # _____

Work telephone #: _____ Other contact #: _____

Email address: _____

Immediate Supervisor: _____

Current work schedule/shift/days worked: _____

Is your position: ☐ Full-time ☐ Part-time

College official(s) contacted about accommodation: _____

DISABILITY INFORMATION:

1. Please indicate the nature of your disability[1]:

   ☐ Visual ☐ Respiratory ☐ Mental/Psychological
   ☐ Hearing ☐ Speech ☐ Learning Disability
   ☐ Mobility ☐ Neurological ☐ Other (please specify) _____

2. Is your disability:

   ☐ Temporary (If so, how long?)_____
   ☐ Permanent

[1] In general, for purposes of this form the term "disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual.

3. Please list any accommodation(s) or service(s) related to your disability that would help you meet the essential functions of your current job:

_____

_____

_____

_____

I hereby agree that the Department of Human Resources can share relevant information from my physician or other health care provider(s) with the supervisor(s) in my immediate work unit and with other College offices that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work responsibilities.
The Department of Human Resources also has my permission to contact my physician or other health care provider(s) for additional information to assist in developing reasonable accommodations for me.
This form should include a description of my disability; any related limitations; and recommendations for accommodation(s) and/or service(s).

_____
Employee Name (Print)

_____ _____
Employee Signature Date

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Please describe any limitations or restrictions which impacts their ability to perform the essential functions of their job:

_____

_____

_____

_____

Health Care Provider's Certification

The signature below indicates that the information provided is an accurate reflection of the employee's health condition and accommodations requested under the Americans with Disabilities Act. (ADA).

_____
Health Care Provider Name (Print)

_____ _____
Health Care Provider Signature Date

Please complete form and send it to HR Benefits Department at PO BOX 13489, Saint Petersburg Florida, 33733