EASTERN WASHINGTON UNIVERSITY

EMPLOYEE REASONABLE ACCOMMODATION REQUEST FORM

Eastern Washington University employees, who are seeking reasonable accommodations for a qualified disability pursuant to the Americans with Disabilities Act (ADA), Section 503 of the Rehabilitation Act of 1973, and/or the Washington State Law against Discrimination (WLAD), are invited to complete this form so that University personnel who are designed to facilitate accommodations can assess whether individuals have a qualifying disability and if so, then engage in an interactive process with the person to evaluate and determine appropriate reasonable accommodations. EWU may require the employee to provide medical information from a licensed heath care professional. The medical documentation will need to describe the nature, severity and duration of the impairment, the activity or activities that the impairment limits, and the extent to which the impairment limits employee's ability to perform the activity or activities; and medical documentation that substantiates why the requested reasonable accommodation is needed. Employees are encouraged to provide complete, candid, and realistic information concerning the nature of the disability, special needs, or any support services required. This information will assist the University in determining whether a person has a qualifying disability and whether an accommodation is reasonable. Medical information that is provided will be retained in a confidential manner, separate from the employee's personnel file.

Name: _____ Date: _____

EWU ID _____ Phone: _____

Address: _____

City/State/Zip: _____

Position: _____ Department: _____

Supervisor: _____

TO BE COMPLETED BY EMPLOYEE: (Use separate sheet if necessary)

Identify and describe the physical or mental disability which is the basis for your reasonable accommodation(s):

What major life activity is substantially limited by this disability?

What do you need to be able to do your job?

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EMPLOYEE CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Purpose of Disclosure of Information:

To determine eligibility for services and accommodations in the post-secondary employment setting (as outlined in Section 503 of the Rehabilitation Act of 1973, Title I of the Americans with Disabilities Act of 1990, and the Washington Law Against Discrimination)

Name of Employee: _____

Job Title: _____

Department: _____

Work Schedule: _____

To: _____
Name of Health Care Provider

Address: _____
Street City State Zip

Phone: _____

Patient's Date of Birth: _____

I hereby authorize the above listed health care provider and any others who have treated me to release to Eastern Washington University the following information related to my health care: diagnosis of relevant condition(s), the severity and duration of the impairment, my ability to perform my work with or without reasonable accommodation, and information as to why the requested reasonable accommodation is needed. I also authorize disclosure and discussion as necessary so that EWU may determine appropriate and reasonable accommodations for me. I understand that information obtained under this release is a confidential medical record and is maintained separately from my personnel file. This authorization is valid for 120 days from date of signature.

I further understand that, if I have a qualifying disability, EWU is not obligated to provide any specific accommodation I request, but will evaluate all information gathered through an interactive process with me and otherwise to make a determination of what is a reasonable accommodation.

Employee Signature: _____ Date _____

Revised: 7/2025