

Disability Accommodation Request Form (Confidential)

Name of person with disability	
Date of Request:	
Address	
Phone Number (include area code)	Work: Home:
Email	Work: Personal:
Affiliation (circle one)	Employee Program Participant (member of public)
<p>Answer these questions only if you are an employee:</p> <ol style="list-style-type: none"> 1. Job Title and classification (classified, academic staff or faculty) 2. Division (UW-Extension) or Campus (UW-Colleges) 3. Supervisor's name and phone number 	
<p>Answer these questions only if you are a program participant (member of the public):</p> <ol style="list-style-type: none"> 1. Program (example: 4-H, Master Gardener, Public Lecture, Small Business Education, etc.) 2. Name and phone number of staff person organizing the program (if known) 3. County or campus where program takes place 	



1. My disability is (asthma, diabetes, depression, etc.):

2. How does your impairment affect your ability to perform work duties (if employee) or participate in programming (if public member)?

3. What accommodations are you requesting? (Attach additional sheets of paper if necessary.)

Send this form, the program announcement or job description, and any accompanying medical documentation to:

**Christine Curley
 ADA Specialist
 432 N. Lake St., Room 501
 Madison, WI 53706
 (608) 265-2406**

To be Completed by ADA Specialist

Request Received on:	
Accommodation Request is (circle one):	Denied Approved Approved with Modifications (attach description):
Signature of ADA Specialist	Date
Signature of Supervisor or Staff Representative	Date
Signature of Financial Authority (i.e. Dean, County Department Head, Human Resource, Grant Coordinator, etc.)	1. 2. 3. <div style="text-align: right;">Date</div>

To be completed by Doctor or other Medical Treatment Professional

Dear Medical Treatment Professional:

Your patient has requested an accommodation with UW Colleges or UW-Extension. In order to fulfill our responsibilities under the Americans with Disabilities Act (ADA) and corresponding Wisconsin laws, I am requesting information about your patient's medical condition. Please answer the following questions:

1. Does this individual have an impairment-diagnosed disability **that substantially limits one or more major life activities**? Major life activities are defined as those that an average person can perform with little or no difficulty, such as caring for oneself, walking, seeing, hearing, breathing, learning, sitting, concentrating, interacting with others, sleeping, etc.

No

Yes: how does the impairment substantially limit one or more major life activities?
Please be as specific as possible.

2. Describe the **nature** (temporary, chronic, permanent, etc.) and **severity** (mild, moderate, severe, etc.) of the impairment.

3. Your patient has requested the accommodations found on page two of this document. Taking into account the activities described in the program announcement or employee job description, please answer the following questions:

Are these accommodations appropriate?

How long will these accommodations be necessary?

Do you suggest any other accommodations?

4. Please sign and date to indicate your agreement with the above medical information:

Signature:

Title:

Phone Number:

Fax:

Address:

Your patient and I greatly appreciate your assistance. Please feel free to contact me at 608-265-2406 if you have any additional questions or concerns.

Sincerely,

Christine Curley
ADA Specialist
432 N. Lake St., Room 501
Madison, WI 53706
Fax:608-262-6572