Reasonable Accommodation Request Form

ADA – Disability Related

Instructions:
The Reasonable Accommodation Request Form (RARF) must be used when an employee seeks a (non-scholastic) accommodation due to a documented disability. To make a request for a reasonable accommodation the employee must:

- Review the Americans with Disabilities Act and Reasonable Accommodation Policy & Procedures.
- Complete this form and return it to the Amber Wagner, ADA Coordinator, 6200 University Center, Bldg. A, Tallahassee, FL 32306-2410 or via fax at (850) 645-9512 or electronically to: amwagner@fsu.edu.
- Submit a Medical Certification of Disability form, if determined necessary by the ADA Coordinator.

Please note: After receiving all documentation, the ADA coordinator will utilize an interactive process with the employee and the appropriate approving authority within the department to determine what accommodation(s) is appropriate and reasonable under the circumstances.

Contact Information (To be completed by the Employee)

Name: _____ Employee ID: _____

FSU Affiliation: ( )Faculty ( )Staff ( )Applicant ( )Other: _____

Phone Number: _____ Email: _____

College/Division: _____ Department: _____

Job Title: _____ Supervisor: _____

Work Location: _____

Work Schedule: _____

Questions regarding this form or the University's ADA policy and procedures may be directed to the Equity, Diversity and Inclusion Office at (850) 645-1458 or amwagner@fsu.edu.

Submit to the ADA Coordinator

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Accommodation Request (To be completed by the Employee)
Attach additional pages if necessary

A. Indicate the physical and/or mental impairment(s) that led to this request for reasonable accommodation and, if applicable, the expected duration of the impairment(s). Please note that it is not necessary to indicate a specific medical diagnosis.

B. Explain how the impairment(s) affect the ability to successfully complete your activity/job at FSU.

C. Specifically describe the accommodation(s) you are proposing.

Release of Information: I hereby authorize the release of the above information to Florida State University, in conjunction with the Medical Certification of Disability, for the purpose of determining if I am a qualified individual with a disability and the appropriateness of the requested reasonable accommodation(s). I further authorize Florida State University to seek clarification of this document and the Medical Certification of Disability, if necessary, by contacting my physician or care provider.

_____ _____

Requestor's Signature Date

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