



office for **EQUAL**
OPPORTUNITY

EMPLOYEE INFORMATION

Name: _____ Employee ID Number _____

Job Title: _____ Work Unit: _____

Work Phone: _____ Work Location: _____

Email Address: _____

Work Schedule: (Days & Hours): _____

SUPERVISOR INFORMATION

Name: _____

Job Title: _____ Work Unit: _____

Work Phone: _____ Work Location: _____

Email Address: _____

This employee has a documented disability that affects his/her ability to perform certain activities in the workplace.

Functionally, this disability manifests itself in difficulty with the following:

This employee qualifies for, and has requested to use the accommodations listed below in the workplace:

Additional comments:

Supervisor Signature: _____

ADA Coordinator Signature: _____

Employee Signature: _____

I have been given a copy of REG 05.002, Reasonable Accommodations in Employment. I have also discussed my functional limitations and accommodation needs with the ADA Coordinator and my supervisor and understand that my documentation indicates I am eligible for the above accommodations. I further understand, that the ADA Coordinator and my supervisor, may share information, as needed, to arrange my accommodations.

The employee should request a review of accommodations if he/she becomes unable to perform the essential requirements of the job.

Disability Services Office
Accommodations Agreement
Form EEO-011

NC STATE UNIVERSITY