

**Request for Information Regarding the Americans with Disabilities Act**

An employee may qualify for a reasonable accommodation under the American with Disabilities Act if an employee has a disability or an impairment that substantially limits one or more major life activities, or a record of such an impairment.

To assist Human Resources with evaluating the employee’s request for accommodation, the entirety of this form must be completed by a medical care provider, and submitted to Human Resources.

Should you have any questions please contact TSC Human Resources directly at 850-201-8510 or via email at [HR.tsc.fl.edu](mailto:HR.tsc.fl.edu). Please return this form via email to [Nyla.Davis@tsc.fl.edu](mailto:Nyla.Davis@tsc.fl.edu) or mail/deliver in person to 444 Appleyard Drive, Tallahassee, Florida 32304.

Name of Employee: \_\_\_\_\_ Position with the College: \_\_\_\_\_

1. Please specify the accommodation being requested: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Based on the accommodations described above and the medical history of the employee, are they able to be on TSC campus?

Yes

No

If not, what other reasonable accommodations would you recommend the College make?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does the employee have a physical or mental impairment?

Yes

No

If yes, what is the impairment?

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4. Does the impairment substantially limit a major life activity when compared to most people in the general population?

Yes

No

Bending	Interacting with Others	Speaking
Breathing	Learning	Standing
Caring for Self	Lifting	Thinking
Concentrating	Performing Manual Tasks	Walking
Eating	Reaching	Working
Hearing	Reading	Other_____

If yes, what major life activity(s)(includes major bodily functions) is/are affected?(please circle all which apply)

<b>Major bodily functions:</b>			
Bladder	Digestive	Lymphatic	Reproductive
Bowel	Endocrine	Musculoskeletal	Respiratory
Brain	Genitourinary	Neurological	Other_____
Cardiovascular	Hemic	Normal Cell Growth	
Circulatory	Immune	Operation of an Organ	

5. What limitation(s) interfere with job performance or accessing a benefit of employment?

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6. What job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?

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7. How does the employee's limitations(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment? Please refer to the enclosed position description.

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8. If it is determined that an accommodation is needed, how long will the employee require an accommodation?

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9. Is there anything else that you would like to share to help the College in making a determination regarding the employee's accommodation request?

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I hereby certify that the facts in this document are true and correct to the best of my knowledge:

Name of Medical Provider: \_\_\_\_\_

Signature of Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_