 **Employee Disability Accommodation Response**

 **Form C**

Supervisors/Managers: Based on your employee’s Disability Accommodation Request please fill in all sections below.

**Note:** **DO NOT include knowledge of employee’s diagnosis, medical condition, or specific illness.**

**EMPLOYEE:**

NAME: JOB TITLE:

**SUPERVISOR:**

1. How were you made aware of the possible need for accommodation or disability issue?
	1. The Employee Accommodation Request [ ]
	2. Through observation or third party [ ]
	3. The exhaustion of state or employer covered leaves [ ]
	4. Other [ ]  If checked, please describe:
2. Is the employee performing the essential functions of the job in a satisfactory manner? [ ]  Yes [ ]  No If no, please identify what essential duties require accommodation.

1. In your opinion, is the accommodation requested by the employee a reasonable request? [ ]  Yes [ ]  No
2. Would the accommodation(s) requested be burdensome on the department or area under your supervision? [ ]  Yes [ ]  No. If yes, please describe:

1. Do you have additional or alternative accommodations that you would like to discuss during the interactive meeting? [ ]  Yes [ ]  No. If yes, please describe:

Dean/Director comments:

 Initial:

Vice President/President comments:

 Initial:

 /

Supervisor Print Name Extension Signature Date