 **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