



Office of Disability Services
77 Massachusetts Avenue, E19-215,
Cambridge, MA 02139
Fax:: 617-253-1502
TTY: 617.258-9344

Employee Reasonable Accommodation Request Form

Name: _____ Dept.: _____

MIT ID # _____ E-mail: _____

Job Title: _____ Work Phone: _____

Immediate Supervisor: _____

Phone: _____

Please provide a detailed description of the accommodation you are requesting:

*Please attach all pertinent recent medical report(s). Please note the medical report(s) must include documentation supporting the need for the requested accommodation.

I am hereby requesting a reasonable accommodation due to my disability. I grant permission to the Disability Manager and individuals identified by the manager as necessary participants in the decision-making process (supervisor, social worker, Safety Office, Benefit officer, worker's compensation representative, etc.) to review the pertinent information I have provided and discuss the matter with me with and my health professional(s).

EMPLOYEE'S SIGNATURE

DATE

All information provided pursuant to this request will be maintained in a separate confidential file.

