Reasonable Accommodation Request Form**

Please complete this form and submit it to Jennifer Burke, Director of Employee Relations and Staffing in the Human Resources Department. Completion of this form will allow us to work together to review and address your request for a reasonable accommodation to perform the essential functions of your job. This information and other related documentation will be treated confidentially and kept separate from your personnel file.

Name:	**Email:**
Department:	**Extension:**
Campus Address:	**Mobile Phone:**
Supervisor/Department Chair Name:	**VP/Dean Name:**
Is your department management aware of your request: ☐ **Yes** ☐ **No**	

ACCOMMODATION REQUEST

Identify the disability that is the basis of your request for reasonable accommodation(s).
Describe the nature and duration of the disability identified above.
Have you been treated by a doctor or other medical professional regarding the disability you have identified? Please provide contact information for anyone you identify.
Describe the accommodation you are requesting. (Please note: if a reasonable accommodation is granted it may be an effective accommodation that is different from the one you specify below.)
Describe how the accommodation you are requesting will enable you to perform the essential function(s) of your job and/or to engage in equal benefits and privileges of employees without disabilities.
Please provide any additional information you believe may be of assistance while we review your request for a reasonable accommodation.

ADDITIONAL MATERIAL

Please attach, or promptly provide, documentation from your medical provider describing the disability, the medical diagnosis, and suggested accommodations. Information provided by the medical provider will help us assess this request and identify appropriate reasonable accommodations. In addition, Berklee reserves the right to affirm and review medical information provided by your medical provider and/or physician and may conduct an independent medical evaluation at the College's cost.

Employee Signature: _____ **Date:** _____

Date received by HR:	
Date review began / reviewer:	
Reasonable accommodations considered:	
Departmental response/date:	
Reasonable accommodation granted:	
Cost of reasonable accommodation:	
Is the reasonable accommodation reoccurring?	
Reason for not providing reasonable accommodation (if applicable):	
Date Employee was notified of results of review:	