Division of Human Resources

AMERICAN WITH DISABILITIES ACT EMPLOYEE SELF REFERRAL

Date:_____

Directions: Please complete this form (*print or type the information*), sign, date, and return to the Human Resources Department, Attn.: Bart Brooks. Please attach additional sheets as necessary.

_____ _____
Name *Employee ID*

_____ _____ _____
Home Address *Home Phone* *Work Phone*

_____
City, State, Zip

_____ _____
Worksite *Job Title*

_____
Immediate Supervisor

1. Do you consider yourself to be disabled? If yes, please describe your disability.

   _____

   _____

   _____

2. Are you limited in your major life activities/functions because of this disability? Yes ☐ No ☐

3. Which major life activities/functions are substantially limited by this disability and how are they limited. Major life activities are defined as caring for oneself, performing manual tasks, and walking, seeing, hearing, speaking, breathing, learning and working.

   _____

   _____

   _____

4. Can you perform the essential functions of your job responsibilities with or without reasonable accommodations? Yes ☐ No ☐

   If the answer is no, please explain in detail which essential functions you cannot perform.

   _____

   _____

   _____

5. What reasonable accommodations do you suggest?

   _____

   _____

   _____

_____ _____
Employee Signature *Date*