



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.: Alisha R. Williams. 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