

ADEC Approved: _____ Date: _____

ADEC Not Approved: _____ Date: _____

Discussion: _____



HUMBOLDT STATE UNIVERSITY

Department of Human Resources

Assistive Device Equipment/Auxiliary Assistance Information Request Form

NAME: _____

JOB CLASSIFICATION: _____

Working Job Title: _____

Department: _____ Department Phone Number: _____

Email address: _____ Office Phone Number: _____

Check One below:

Status of Position: _____ Faculty _____ Staff _____ Administrator (MPP)

 _____ Temporary _____

(Indicate end date of appointment and if position is eligible for renewal)

Disabling condition(s):

Is disabling condition permanent?

What are the essential job functions for which reasonable accommodation is being requested?

Has disability been verified? Yes No

Please indicate from whom (medical doctor; licensed health care practitioner, rehabilitation professional) and attach verification.