Request for
Disability Accommodation and Services

Name: ___________________________________________ Date: ______________

Contact Information: ______________________________________________________

1. What is your disability? Please specify the date your disability commenced and its expected duration.

2. What is the reasonable accommodation(s) that you are requesting? Be as clear and specific as possible.

3. Please explain how the requested accommodation, aid or assistance measure will help you.

4. Please explain if there are other accommodations, aids or assistance measures which may assist you.

5. Are there any elements that you cannot complete without the accommodation you are requesting? If so, please explain.

6. Are there any elements that you cannot complete even with the accommodation you are requesting?
I, ________________________________, request that the above accommodations be provided to me as an individual with a disability, as defined by law and qualified to meet the fundamental requirements and aspects, without undue hardship.

The information that I have provided is true, correct, and complete. I hereby authorize, ________________________________, my treating physician and/or other related health care professional(s) to provide information regarding my condition.

________________________________________  __________________________
Signature                                      Date
Physician's Disability Certification

This is a certification that the named individual below, was determined by a physician to have met the Americans with Disabilities Act (ADA) definition of an "individual with disability (ies)" in accordance with the ADA disability criteria below:

Name: __________________________________________

Date of Birth: ____________________________________

_____ Has a physical and/or mental impairment that substantially limits one or more of the major life activities of the individual.

_____ Has a record of such impairment; and/or

_____ Be regarded as having such an impairment.

PHYSICIAN USE ONLY

Disability ____________________________________________

_____ Permanent   _____ Temporary   ____________________________
(Length of Certification)

Name of Physician: ________________________________

Address: _________________________________________

Contact Number(s): _______________________________

Physician’s Signature: _____________________________  Date

Physician or Clinic Stamp: __________________________

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