



Workplace Accommodations Agreement Form

The information provided below outlines the disability-related employment accommodations being provided for:

Employee:

ID:

Department:

Division:

The following accommodations are provided at no cost to the above Texas State employee based upon the disability-related needs of the employee as requested and approved by the ADA Compliance Coordinator in consultation with the Texas State Workplace Accommodation Interactive Team. These accommodations were determined based on the following documentation provided by the employee:

Type of documentation provided/Name of Specialist:

Additional Information:

Date(s) of documentation: See information above **Effective Date(s) for Accommodations:** [Start – End Dates]

Recommended Accommodations

As the employee requesting accommodations, I understand the accommodations outlined above, which my supervisor has agreed to provide, are based on the reviewed documentation submitted for this request and supplemental documentation will be required if additional accommodations are necessary to meet my disability-related needs.

Signature of Faculty/Staff Member

Date

Supervisor's Signature

Date

Signature of Dean/Director

Date

Signature of Divisional Vice President/Provost/Athletic Director

Date

Signature of ADA Compliance Coordinator

Date