ADA Employment Reasonable Accommodation Acknowledgement

Employee Name:_____ Identification #:_____

Work Phone:_____ Work Email:_____

Agency:_____ Division:_____

Job Title:_____ Work Location:_____

Union & Local #:_____

Supervisor/Manager Name:_____

Work Phone:_____ Work Email:_____

This acknowledgement follows the State Reasonable Accommodation Policy under the Americans with Disabilities Act (ADA). The parties have determined the reasonable accommodation(s) to enable the employee to perform the essential functions of the job. This acknowledgement results from all released information and the interactive process among the parties.

Describe the accommodation(s) that the Agency shall provide to the employee:

Describe any actions to provide the accommodation(s), including ordering, purchasing, delivery, installation, or training:

The parties accept the accommodation(s). The parties note that any of them may periodically review the accommodation(s) to ensure that it continues to be necessary and effective. Any accommodation item(s) that the Agency procures for the employee remains the property of the State of Minnesota.

Signatures

Employee: By checking this box, I agree my electronic signature is the legal equivalent of my manual signature on this acknowledgement.

☐ Employee _____ Date _____

Supervisor/Manager: By checking this box, I agree my electronic signature is the legal equivalent of my manual signature on this acknowledgement.

☐ Supervisor/Manager _____ Date _____

ADA Coordinator: By checking this box, I agree my electronic signature is the legal equivalent of my manual signature on this acknowledgement.

☐ ADA Coordinator _____ Date _____