Workplace Accommodation Agreement

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 Americans with Disabilities Act coordinator, in consultation with the Texas State Workplace Accommodation Interactive Team (WAIT) or Office of Disability Services (ODS) staff. These accommodations were determined based on the following documentation provided by the employee:

Type of documentation provided/Name of specialist: ___________________________

_________________________  Date(s) of documentation: ____________

<table>
<thead>
<tr>
<th>Accommodations</th>
<th>Effective Dates</th>
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<tbody>
<tr>
<td>1. ____________________</td>
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<td>2. ____________________</td>
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<td>3. ____________________</td>
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Last date accommodation will be required (if applicable): ___________________________

As the employee requesting accommodations, I understand the accommodations outlined above which my supervisor has agreed to provide, are based on the 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 Workplace Accommodation Interactive Team Member  Date

_________________________________________  _______________________
Signature of Divisional Vice President  Date