Illinois Appellate Court, Fifth District
Request for Accommodation under the Americans with Disabilities Act
(REQUEST TO REMAIN CONFIDENTIAL)

Please Print:

Date: _____

Name of person requesting accommodation:_____

Address:_____

Daytime phone number: _____E-mail: _____

Type of accommodation requested (please be specific): _____

_____

_____

Date accommodation is needed:_____

Location where accommodation is needed: _____

_____

Please send a copy of this completed form by mail to:

Appellate Court Disability Coordinator
Office of the Illinois Appellate Court Clerk, Fifth District
14th & Main St., P.O. Box 867
Mt. Vernon, IL 62864
or by e-mail at the address listed on page 2 of the policy
Phone: (618) 242-3120

Please sign to verify the foregoing information:_____

Please print name:_____

_____

Office Use Only:
Accommodation: _____granted: _____ denied:_____

Requestor notified on:_____via:_____

Type of accommodation: _____

Comments: _____

_____

EXHIBIT B

Print Form Save Form