

#  Request for Reasonable Accommodation

**Section A: Employee Information**

(This section must be completed by the employee/applicant requesting an accommodation.)

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| --- | --- |
| **1. Employee/Applicant Name:** |       |

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| --- | --- |
| **2. Work Location:** |       |

|  |  |
| --- | --- |
| **3. Work Phone Number:** |       |

|  |  |
| --- | --- |
| **4. Email Address:** |       |

|  |  |
| --- | --- |
| **5.** | **Description of requested accommodation:** |
|  |        |

|  |  |
| --- | --- |
| **6.** | **This accommodation is necessary because:** |
|  |        |

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| --- | --- | --- |
|  |  |  |
| *Signature (Employee/Applicant)* |  | Date |

**Section B: Supervisor Information**

(This section must be completed by the supervisor of the employee/applicant requesting an accommodation prior to submission to a medical provider.)

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| **1. Supervisor’s Name:** |       |

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| --- | --- |
| **2. Work Location:** |       |

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| --- | --- |
| **3. Work Phone Number:** |       |

|  |  |
| --- | --- |
| **4. Email Address:** |       |

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| --- | --- |
| **5. Date Request Received from Employee/Applicant:** |       |

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| --- | --- |
| **6.** | **Supervisor’s comments/recommendations on employee/applicant requests, and list of accommodations already provided to the employee/applicant, if applicable:** |
|  |       \_\_\_\_\_\_ |

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| --- | --- |
| **7.** | **Medical Provider Referral Required?** **[ ]  Yes** **[ ]  No If yes, Supervisor must list the essential job function(s) in Section C(4).** |

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| *Signature (Supervisor)* |  | Date |

**Section C: Medical Inquiry Form in Response to an Accommodation Request**

(This section must be completed by an appropriate health care or rehabilitation professional.)

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| As discussed, the form will be returned to the supervisor by: |       |  |
|  | *(Date)* |  |

Employee/applicant must notify the supervisor of any changes that may impact the submission of the form.

**1. Questions to help determine whether an employee has a disability:**

A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. The following questions may help determine whether an employee has a disability:

Does the employee/applicant have a physical or mental impairment? Yes [ ]  No [ ]

What is the impairment?

Can the impairment be corrected by medication or other means? Yes [ ]  No [ ]

Is the impairment long-term or permanent? Yes [ ]  No [ ]

If the impairment is temporary (short-term), what is the expected duration of impairment? \_\_\_\_\_\_\_\_\_\_\_\_\_

Does the impairment affect a major life activity? Yes [ ]  No [ ]

If yes, what major life activity(ies) is/are affected?

[ ]  Caring for Self

[ ]  Interacting With Others

[ ]  Performing Manual Tasks

[ ]  Breathing

[ ]  Working

[ ]  Walking

[ ]  Standing

[ ]  Reaching

[ ]  Thinking

[ ]  Toileting

[ ]  Hearing

[ ]  Seeing

[ ]  Speaking

[ ]  Learning

[ ]  Sitting

[ ]  Lifting

[ ]  Sleeping

[ ]  Concentrating

[ ]  Reproduction

[ ]  Other: (describe)

Is the employee/applicant substantially limited in one or more of these major life activities?

Yes [ ]  No [ ]

**2. Questions to help determine whether an accommodation is needed:**

An employee/applicant with a disability is entitled to an accommodation when such a change to a job, the work environment or the way things are usually done would allow the individual to perform job functions or enjoy equal access to benefits available to other individuals in the workplace. The following questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) is interfering with the employee’s/applicant’s ability to perform the essential function(s) of the job?

|  |
| --- |
|        |

How does the employee’s/applicant’s limitation(s) interfere with his/her ability to perform the essential function(s) of the job?

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| --- |
|       Are Ar |

Do you believe the limitations which interfere with the ability to perform the essential functions are short-term?

Yes [ ]  No [ ]

If yes, what is the expected duration of the need for an accommodation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Questions to help determine effective accommodation options:**

If an employee/applicant has a disability and needs an accommodation because of the disability, the employer must provide reasonable accommodation(s), unless the accommodation(s) poses an undue hardship on the operations of the organization and/or causes direct threat to the health and safety of employee/applicant, customers/clients, or others. The following questions may help determine effective accommodations:

Do you have any suggestions regarding possible accommodations to improve the employee’s/applicant’s ability to perform the essential function(s) of the job? If so, what are they?

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How would your suggestions improve the employee’s/applicant’s ability to perform the essential function(s) of the job?

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**4. Assess whether essential job function(s) can be performed (attached additional sheets as required):**

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| --- | --- | --- | --- |
| **Yes** | **No** | **Yes, with****Reasonable****Accommodation** | **Essential Function/Duty** |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |
| [ ]  | [ ]  | [ ]  |       |
|  |  | Explain: |       |

**5. Additional Comments:**

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|        |

**6. Medical Provider Information:**

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| --- | --- |
| **Name (printed):** |       |
| **Address:** |  |
| **Telephone:** |       |

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| --- | --- | --- |
|  |  |  |
| *Medical Professional’s Signature* |  | Date |

**Section D: Appointing Authority’s Decision**

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| **1.** | **The following accommodation(s) is(are) approved:** |
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|  |  |
| --- | --- |
| **2.** | **The following accommodation(s) is(are) not approved:** |
|  |        |

|  |  |
| --- | --- |
| **3.** | **The reason(s) for not approving the accommodation(s) requested is(are):** |
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| --- | --- | --- |
|  |  |  |
| *Signature (Appointing Authority)* |  | Date |

(Attach more pages or documents as needed)

**Give a copy of the completed form to the employee/applicant.**

**Forward the completed form to the agency’s Human Resources Associate (HRA).**

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| --- |
| **Human Resources Associate:*** If approved, create a 269 P1.
* Keep this form and any attachments in a confidential file that is kept separate from the employee’s personnel file.
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