EMPLOYEE REQUEST FOR REASONABLE ACCOMMODATION

This form is completed by an employee who is requesting accommodation(s) for performing essential job duties. Sign and forward the completed form to the AGENCY's Human Resource Representative for review and approval. Please print or type in the requested information.	
Employee Name/Title	
Unit/Division	
Work Location	
Telephone Number	
Supervisor's Name/Title	
Date of Request	

In accordance with the Americans with Disabilities Act, as amended, an employee with a disability has an impairment that substantially limits one or more major life activities or has a record of such an impairment. The information you provide will be used in discussions with Human Resources to determine if a reasonable accommodation will assist you to complete the essential job duties assigned to your position. Your treating health care practitioner may need to complete the ADA Medical Certification Form as advised by Human Resources. Include attachments as needed.	
Describe your physical or mental impairment(s)	
How do/does the impairment(s) interfere with your completion of essential job duties or your ability to participate in other privileges of employment?	
What accommodation(s) are you requesting?	
How will the accommodation(s) assist you to complete your essential job duties?	

Employee Certification:

• My signature below certifies that the information I've provided is a truthful and accurate request for an ADA accommodation. I acknowledge that my treating health care practitioner may need to complete the ADA Medical Certification Form as requested by Human Resources specific only to my request for job accommodation(s).

• This information will be reviewed by Agency Human Resources and maintained in a confidential and secured location.

• Managers and supervisors may receive instructions related to the final determination on a need-to-know basis.

Employee Signature	**Date (Month/Date/Year**