LOG#:

REQUEST FOR REASONABLE ACCOMMODATION

Part A: Completion by EMPLOYEE

Employee First Name:	Employee Last Name:	
Employee Position Description:	Employee Work Unit:	Work Phone Number:
Work Location Address:		Bargaining Unit:
Home Address:		Home Phone Number:

IDENTIFY THE SPECIFIC LIMITATION WHICH REQUIRES ACCOMMODATION (e.g. "may not lift over 25 pounds for six months):

IS THE ABOVE-MENTIONED LIMITATION:

Permanent ☐
Temporary ☐ If temporary, anticipated recovery date_____
Unknown ☐

DESCRIBE THE ACCOMMODATION REQUESTED:

☐ Architectural Changes ☐ Assistive Device/Equipment ☐ Jobsite Modification
☐ Restructure Job Duties ☐ Other (Specify):

SPECIFY HOW THIS ACCOMMODATION WILL ASSIST YOU TO PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION:

Part B: Medical Substantiation

Verification by a Health Care Provider for your Reasonable Accommodation must meet the following criteria:

● The documentation must be written on the official letterhead of the qualified health professional or health professional's organization.
● The qualified health professional's credentials must be identified, i.e., M.D., R.N., physical therapist.
● The documentation must be dated and signed by the health professional.
● The limitations must be described in detail as they currently exist and only in relationship to the employee's job duties.
●The documentation must indicate whether the disability is temporary or permanent. If temporary, the date the disability is expected to end must be specified.

I have read and understand Part B,

Employee Signature:	**Date:**

NOTE: IT IS THE EMPLOYEE'S RESPONSIBILITY FOR ANY EXPENSE INCURRED IN PROVIDING MEDICAL DOCUMENTATION TO THE DEPARTMENT.

Part C: For Completion by the EMPLOYEE'S SUPERVISOR	
Supervisor Name:	**Work Phone Number:**

1. Have you discussed the essential functions and limitations with the employee? Yes☐ No☐
2. Can the limitations be accommodated in present position? Yes☐ No☐

Explanation:

Supervisor Signature:	**Date:**

Part D: For Completion by the RETURN TO WORK COORDINATOR

Date acknowledgement letter sent to employee:_____

This request is:
☐ Approved ☐ Modified ☐ Denied

Explanation:

Return to Work Coordinator Signature:	**Date:**
Personnel Manager Signature:	**Date:**