If you need help filling out this form, please ask your supervisor or Human Resource Manager.

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| --- | --- | --- | --- |
| **Employee Name:** |  | **Supervisor’s Name:** |  |
| **Employee #:** |  | **Agency:** |  |
| **Phone Number:** |  | **City:** |  |

|  |  |  |
| --- | --- | --- |
| **A. Questions to clarify accommodation requested.** | | |
| What specific accommodation are you requesting? |  |  |
| If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? | Yes | No |
| If *yes*, please explain. |  |  |
| Is your accommodation request time sensitive? | Yes | No |
| If *yes*, please explain. |  |  |
| **B. Questions to document the reason for accommodation request.** | | |
| What, if any, job function are you having difficulty performing? |  |  |
| What, if any, employment benefit are you having difficulty accessing? |  |  |

|  |  |  |
| --- | --- | --- |
| What limitation is interfering with your ability to perform the essential func an employment benefit?  Have you had any accommodations in the past for this same limitation? | tions of you  Yes | r job or access  No |
| If *yes*, what were they and how effective were they? |  |  |
| If you are requesting a specific accommodation, how will that accommodation assist you with your job or accessing a benefit? | | |
| Is your request accompanied by an ergonomic assessment? | Yes | No |
| Do you have a note from your doctor? | Yes | No |
| **C. Other.** | | |
| Please provide any additional information that might be useful in processing your accommodation request: | | |
| **Date:** | | |
| Employee Signature |  | |
| **Return this form to your Supervisor with a copy to your Human Resource Manager.** | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **D. Agency action.** | | | | | | | |
| Approved: Yes |  | No |  |  | | | |
| Comments: | | | | | | | |
| **Supervisor Signature:** | | | | |  | **Date:** |  |
| **Next-Level Supervisor Signature:** | | | | |  | **Date:** |  |
| **Secretary/Commissioner Signature** | | | | |  | **Date:** |  |

Approval of accommodation does not automatically indicate that the employee has an ADA qualifying disability.

Send copy of completed form to the Human Resource Manager for employee’s file.