Reasonable Accommodation Request - Confidential

This form and any supporting materials or information is confidential and should be kept separate from an employee's personnel file.

SECTION A: TO BE COMPLETED BY EMPLOYEE

Name of Employee ______________________ Classification/Job Title ______________________

Work Location/Supervisor ______________________ Work Telephone Number/Email ______________________

Accommodation(s) Requested
(Be as specific as possible, for example, adaptive equipment, reader, interpreter, training, schedule change, etc. Attach additional pages, if needed.)

Reason for Request
(**Please do not disclose your underlying diagnosis or medical condition**; explain your disability-related limitations and how this accommodation will help you do your job. Attach additional pages, if needed.)

Is your limitation: ☐ Permanent ☐ Temporary ☐ Unknown

Anticipated Recovery Date (if any) ______________________

Is the above described disability the subject of a worker's compensation claim?
(Employees with work-related injuries may also be eligible for a reasonable accommodation independent of the worker's compensation process.)

☐ Yes ☐ No If yes, date filed: ______________________

Have you requested FMLA, CFRA, PDL or other leave in conjunction with the above described disability?

☐ Yes ☐ No If yes, please specify what you requested and when: ______________________

I certify that I have a disability that requires reasonable accommodation, which will be met by the accommodation(s) listed above.

______________________ ______________________
Signature of Employee Date

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SECTION B: CERTIFICATION FROM PHYSICIAN/HEALTH CARE PROVIDER

This employer is requesting a certification from a health care provider verifying that an accommodation is necessary. An employer may request this information when the employee's disability or need for accommodation is not apparent or known.

Attached is a list of the essential functions of ______________________________ (Employee Name)

For the job title: ______________________________

Please provide a letter or verification addressing the following:

1. Verification that the employee has a disability (but not the diagnosis).
2. Description of how the employee's limitations impair the ability to perform the duties of the job (See attached list of essential functions).
    a. Indicate whether these limitations are temporary or permanent.
    b. If temporary, state when they are expected to end.
3. Recommendation of specific reasonable accommodation(s) that would allow the employee to perform the essential functions of the job.
    a. If no accommodation is necessary, please indicate.

(Note: Use the space below or attach a letter or verification, which will be kept confidential. Employers must generally retain medical certifications and related documents separately from usual personnel files.)

Date Accommodation to Begin ______________ Date Accommodation to End or Continuous ______________

Name of Health Care Provider

Address

City State Zip Code

Telephone

Health Care Provider Signature

Return form to:

Representative

Company Name

Address

City State Zip Code

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SECTION C: INTERACTIVE PROCESS DISCUSSION AND RECORD TO BE COMPLETED BY EMPLOYER

1. Acknowledgment of Receipt of Reasonable Accommodation Request ____________________
Date

2. Date Medical Documentation Received ____________________
Date

3. Document all interactive discussions with employee, including dates of the discussions, employee's specific request(s), names of all persons present, and what was discussed. Use additional pages, if required.

Date Discussion Notes

4. List all potential reasonable accommodations identified in the interactive discussions.

5. List your recommended reasonable accommodations.

No employee medical information should be listed on this record. Any medical information should be kept in a separate, confidential medical file.

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SECTION D: TO BE COMPLETED BY EMPLOYER

Status of Request

☐ Accommodation Granted on ____________________ (date)

Date Accommodation to Begin ____________________

Date Accommodation to End (or Continuous) ____________________

Date Equipment Ordered If Needed and by Whom ____________________

Date Equipment Received by Employee ____________________

List specific accommodation(s) to be provided:

____

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☐ Accommodation Denied on ____________________ (date)

For each accommodation requested by the employee that you deny, explain the reason for the denial (may check more than one box, use additional pages if needed):

☐ Accommodation ineffective

☐ Accommodation would cause undue hardship. Identify hardship: ____________________

☐ Medical documentation inadequate

☐ Accommodation would require removal of an essential job function. Identify function:

____

☐ Accommodation would require lowering of performance or production standard. Identify standard:

____

☐ No alternative vacant position available. Positions considered: ____________________

☐ Employee rejected alternative accommodation. Identify accommodation offered and reason for employee's rejection:

____

☐ Other (please identify) ____________________

Further explanation/comments:

____

____

____

____

____________________ Date

____________________ Signature

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SECTION E: TO BE COMPLETED BY EMPLOYER FOLLOWING IMPLEMENTATION OF THE ACCOMMODATION(S)

Check in periodically with the employee to ensure that the accommodation is effective. If the accommodation is not effective, reengage in the interactive process.

Document all interactive discussions with employee, including dates of the discussions, names of all persons present, what was discussed and next step, if needed. Use additional pages if needed.

Date	Discussion Notes
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