

**Request for Reasonable Accommodation-Confidential**

<b>SECTION A: TO BE COMPLETED BY EMPLOYEE</b>	
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.):	
REASON FOR REQUEST (Please do not disclose your diagnosis; explain your disability-related limitations and how this accommodation will help you do your job.)	
IS YOUR LIMITATION: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> 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.) <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE FILED:	
HAVE YOU REQUESTED FMLA OR OTHER LEAVE IN CONNECTION WITH THE ABOVE DESCRIBED DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> 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

**SECTION B:**

**CERTIFICATION FROM PHYSICIAN/HEALTH CARE PROVIDER:**

When an employee's disability or need for accommodation is not apparent or known to the employer, the employer may request a certification from a health care provider verifying that an accommodation is necessary. The employer should provide the employee with a copy of a job duty statement to share with the health care provider.

For completion by the health care provider: 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 and indication of whether these limitations are temporary or permanent.
  - a. If temporary, state when they are expected to end.
3. Recommendation of specific reasonable accommodation(s).

**(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

SIGNATURE OF HEALTH CARE PROVIDER

**SECTION C: INTERACTIVE PROCESS DISCUSSION TO BE COMPLETED BY EMPLOYER**

1. 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
------	------------------

2. List all potential reasonable accommodations identified in the interactive discussions and the strengths and weaknesses for each as a potential reasonable accommodation.

3. State your recommended reasonable accommodation and the rationale for your recommendation.

**SECTION D: TO BE COMPLETED BY EMPLOYER**

LIST SPECIFIC ACCOMMODATION(S) TO BE PROVIDED:

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:

<b>DATE</b>	<b>SIGNATURE</b>
ACKNOWLEDGEMENT OF RECEIPT OF REASONABLE ACCOMMODATION REQUEST	<b>DATES</b>
DATE ACCOMMODATION TO BEGIN	
DATE ACCOMMODATION TO END	
DATE EQUIPMENT ORDERED IF NEEDED AND BY WHOM	

DATE EQUIPMENT WAS RECEIVED BY EMPLOYEE	
-----------------------------------------	--

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

The employer should check in periodically with the employee to ensure that the accommodation is effective. If the accommodation is not effective, there is a duty to 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 steps if needed. Use additional pages if needed.

Date	Discussion Notes
------	------------------

--	--