

# REASONABLE ACCOMMODATION REQUEST FORM

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Department: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

## Section 1 – Disability and Accommodation Needs

Please describe the nature of your disability or medical condition that requires a reasonable accommodation. You may attach additional documentation if necessary.

Description:

Accommodation Requested:

## Section 2 – Impact on Job Duties

Explain how your disability or medical condition affects your ability to perform essential job functions and how the requested accommodation will assist you.

Explanation:

## Section 3 – Medical Provider Information

Provide the name, address, and contact information of the medical provider verifying your disability and the need for accommodation.

Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## Section 4 – Employee Certification and Authorization

I certify that the information provided is true and complete to the best of my knowledge. I authorize the employer to contact my healthcare provider for additional information if necessary to evaluate this accommodation request, subject to applicable privacy laws.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Section 5 – Employer Use Only

Accommodation Request Received By: \_\_\_\_\_

**EMPLOYEE SIGNATURE**

**EMPLOYER REPRESENTATIVE SIGNATURE**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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