CONFIDENTIAL **REQUEST FOR ACCOMMODATION FORM** CONFIDENTIAL

*This form may be completed by job applicants or employees requesting an accommodation. Job applicants/employees should submit the completed form to the interviewer/supervisor. (For all items, attach additional pages, if necessary.)*

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| 1. REQUESTOR’S NAME (PRINT) | 2. EMPLOYEE ID NUMBER |
| 3. HOME MAILING ADDRESS  | 4. OFFICE/WORK ADDRESS |
| 5. WORK TELEPHONE NUMBER (INCLUDE AREA CODE) | 6. HOME AND/OR CELL PHONE NUMBER (INCLUDE AREA CODE) HOME: CELL: |
| 7. JOB/POSITION TITLE | 8. DATE OF REQUEST FOR ACCOMMODATION |

*Please answer the following questions. The information you provide will be treated confidentially and will be handled on a need-to-know basis.*

1. What are the functions of the position which would be or are affected by your disability?

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2. Describe the type of accommodation, which will enable you to perform the essential functions of the position.

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3. Do you have documentation to support your disability? YES\_\_\_\_ NO\_\_\_\_ If YES, please attach documentation.

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| REQUESTOR’S SIGNATURE | DATE |
| SUPERVISOR’S/INTERVIEWER’S SIGNATURE | DATE |
| SUPERVISOR’S/INTERVIEWER’S COMMENTS: |

*Upon completion, the supervisor/interviewer should process this form in accordance with agency procedures.*

For information or assistance regarding accommodation requests please contact the agency Disability Services Coordinator. All requests for accommodation will be reviewed in accordance with *Management Directive 205.25*.

Unless the disability is apparent, agencies may request medical verification or documentation from an employee to support a request for reasonable accommodation using the Health Care Provider Questionnaire available through the Disability Services Coordinator.

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| ACTIONS TAKEN/DETERMINATION MADE/DATES: |
| DATE OF DECISION: | DATE EMPLOYEE/APPLICANT NOTIFIED OF DECISION: |