Reasonable Accommodation Request Form

Date: _____

Employee's Name: _____

Phone: _____ Email: _____

Job title: _____ Department: _____

Supervisor's name: _____

Describe the nature, extent, and duration of your impairment/ disability:

_____

_____

Describe the accommodations you believe are needed to enable you to perform the essential functions of this job:

_____

_____

Provide the name, address, telephone, and fax numbers of your health care provider. The provider may receive a request from us for information regarding your impairment/disability and recommendations for accommodations.

_____

_____

_____

Attach any supporting documentation that may be helpful in evaluating this request for accommodation.

I authorize the release of information regarding my disability to Work Services Corporation management as deemed necessary by Human Services to facilitate this request for accommodation. **Please return form to the Human Services Department ensuring to encrypt/ protect provided information.**

Employee signature: _____ **Date:** _____