

# APPLICATION - REASONABLE ACCOMMODATION

DATE \_\_\_\_\_

## INSTRUCTIONS

Handicapped applicants or employees requesting a reasonable accommodation of their handicap are requested to complete Sections A, B, C, and D.

### SECTION A - Reasonable Accommodation - General Information

1. Name of Employee/Applicant \_\_\_\_\_  
(Last) (First) (Initial)

\_\_\_\_\_  
(Social Security Number) (Work Site Telephone) (Home Telephone)

\_\_\_\_\_  
(Home Address) (City) (Zip Code)

\_\_\_\_\_  
(Work Location) (Classification) (Permanent/Temporary)

2. Statement of Problem/Condition: Describe the condition for which you are requesting an accommodation, including the status of your problem/condition (e.g., permanent, temporary, improving, etc.). Also, describe the impact upon your performance (as an employee), identifying specific tasks, activities, etc., and how they are affected. Specific limitations must be outlined. Use attached additional pages if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### SECTION B - Reasonable Accommodation - Specific Accommodation Sought

1. Identify and describe any accommodation(s) that you feel is/are sufficient and necessary. You may also include for Committee consideration several alternate accommodations.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you discussed your request with District personnel? Yes \_\_\_\_ No \_\_\_\_

3. If yes, to whom have you spoken: \_\_\_\_\_  
(Name) (Date)

What was the result of the discussion? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION C - Reasonable Accommodation - Medical Authorization**

Please attach information from your attending physician(s) regarding the medical condition described by you in Section A-2 and complete and sign the Authorization to Receive or Release Information form. Additional copies of this form may be requested from the Affirmative Action Director, if needed. Your application cannot be processed until the Release of Medical Information form is completed and signed by you. Please note that the information provided by your physician must address specific limitations.

**SECTION D - Reasonable Accommodation - Confidentiality**

This application, attachments, and all medical information subsequently requested will be considered as confidential medical information and will be retained by the District, except where released by the applicant for other use.

I certify that all the information contained in this application is true and correct. I understand that if I am granted an accommodation and if it is subsequently determined that the decision was based upon material misrepresentation or falsification, I am subject to disciplinary action by the District, my request will be canceled, and/or I will be subject to immediate consideration for transfer or termination.

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Return application and all attachments to:

(NOTE: Be sure to complete the attached Medical Information Release Form.)

FOR OFFICE USE ONLY:

Date Received: \_\_\_\_\_ Initial \_\_\_\_\_