REQUEST FOR REASONABLE ACCOMMODATION - CONFIDENTIAL

_____ *provides equal employment opportunities and reasonable accommodation to qualified individual with disabilities consistent with relevant federal, state, and local laws. A reasonable accommodation is any appropriate measure that would allow an employee with a disability/medical condition to perform the essential job functions of their regular job unless the accommodation would present an undue hardship to the business operation. Pursuant to State and Federal Laws and our Reasonable Accommodation Policy, we are committed to assisting employees in identifying an appropriate reasonable accommodation through a good-faith interactive process. Specific information must be ascertained in order to establish that a disability / medical condition exist and to determine a potential accommodation that would enable the employee to perform the essential job functions of their regular job. We are committed to exploring all options for reasonable accommodation(s). This is best achieved with your participation.*

Each of your requests for reasonable accommodation will be assessed and responded to in an upcoming meeting known as the "Interactive Process". Each of your requests for reasonable accommodations will be explored on a case-by-case scenario. The information you provide on this form and all noted supporting documents will be used at this upcoming interactive meeting. This meeting will be held in compliance with the Fair Employment Housing Act.

NOTICE TO EMPLOYEE: *This form and the information contained within are strictly confidential and will be maintained in a separate confidential file from your personnel file. The information you provide will only be used to determine a potential and appropriate accommodation necessary for you to perform the essential job functions of your job. Access to the information outlined in this form will be limited only to those on a need-to-know basis. For more information, you may contact* _____

_____

1. EMPLOYEE'S INFORMATION

(a.) ***FULL NAME:***	*(b.)* ***DATE OF THIS FORM:***
(c.) ***HOME ADDRESS:***	
(d.) ***WORK PHONE:***	*(e.)* ***HOME PHONE:*** / *(f.)* ***EMAIL:***
(g.) ***PREFERRED METHOD OF CONTACT (check all that apply):*** ☐ **Home Phone** ☐ **Work** ☐ **Email** ☐ **U.S. Mail**	
(h.) ***REGULAR / CURRENT JOB TITLE:***	*(i.)* ***DEPARTMENT / DIVISION:***

(j.) ***WHAT IS YOUR CURRENT WORK STATUS : (check all that apply)***

☐ **Not Working** ☐ **Working Full Time, Regular Job** ☐ **Working Part Time / Partial Hours** ☐ **Working Full Time, Alternative Job**

☐ **Totally Temporarily Disabled** ☐ **Partially Temporarily Disabled** ☐ **Currently on Medical Leave FMLA / CFRA / PDL**

☐ **Currently Permanent & Stationary / Maximum Medical Improvement** ☐ **Working Full Time, Light Duty**

☐ **Other:** _____

2. MY REQUEST FOR REASONABLE ACCOMMODATION

(a.) **THE FOLLOWING ARE OPTIONS FOR REASONABLE ACCOMMODATION THAT MAY BE AVAILABLE TO YOU. PLEASE CHECK THE BOX OF THE TYPE(S) OF REASONABLE ACCOMMODATIONS YOU WOULD LIKE TO EXPLORE AT THIS TIME. FOR EACH BOX CHECKED, PLEASE DESCRIBE YOUR SPECIFIC REQUEST FOR ACCOMMODATION IN THE SPACE PROVIDED BELOW:**

☐ *temporary light duty work* ☐ *modification to current Workplace Policies* ☐ *a work site modification that allows me accessibility to structure and/or job site* ☐ *reassignment to a vacant position within my current job class* ☐ *a qualifying leave policy, I could exercise paid or unpaid leave* ☐ *modifications to existing equipment or devices* ☐ *purchase of assistive equipment / devices* ☐ *adjustment to training or testing procedure* ☐ *job to be restructured to accommodate my work restriction* ☐ *paid or unpaid leave to allow for my recovery or improvement from current work limitations / work restriction* ☐ *a redesign of my current workload patterns* ☐ *modification of my current work schedule / shift* ☐ *assistance of another employee* ☐ *OTHER:* _____

_____
_____
_____
_____
_____
_____

(b.) ***HOW WOULD THE ABOVE NOTED ACCOMMODATION(S) OPTIONS HELP YOU PERFORM THE ESSENTIAL FUNCTIONS OF YOUR CURRENT JOB?***

***** USE ADDITIONAL PAGE(S) TO MAKE ADDITIONAL REQUEST FOR REASONABLE ACCOMMODATION *****

3. REASON FOR REASONABLE ACCOMMODATION REQUEST

(a.) ***IS YOUR REQUEST FOR REASONABLE ACCOMMODATION A TIME SENSITIVE MATTER?***

☐ **NO** ☐ **YES** (*if yes, please explain why and by what specific date you will need a response.)*

(b.) ***WHAT IS THE PURPOSE OF YOUR REQUEST FOR AN INTERACTIVE MEETING. (Check all applicable box(s) below)***

☐ For A Non-Industrial Related / My Own Serious Medical Condition ☐ For A Work Related Injury / Medical Condition
☐ Current Reasonable Accommodation In Place No Longer Meet my needs ☐ My Work Restrictions Have Changed
☐ Released to full duty with NO Work restrictions ☐ Need for Equal access / benefits of available services / activities ☐ Released to return to work with work restrictions ☐ OTHER: _____

(c.) ***IN SPACE BELOW, PLEASE OUTLINE YOUR CURRENT WORK RESTRICTIONS / WORK LIMITATIONS. IDENTIFY AND/OR DESCRIBE ANY CURRENT MEDICAL WORK RESTRICTIONS THAT AFFECT YOUR ABILITY TO PERFORM YOUR CURRENT ESSENTIAL JOB FUNCTIONS. DO NOT PROVIDE INFORMATION PERTAINING TO YOUR CURRENT MEDICAL CONDITION OR DIAGNOSIS. SELECT ONE OF THE FOLLOWING BY CHECKING BOX***

☐ My current work restriction(s)/work limitation(s) in need of reasonable accommodation(s) are/is as follows.

_____
_____
_____
_____
_____
_____
_____
_____

☐ The following is a list of medical note(s). Please provide a copy of each medical note/set of work restrictions in need of accommodation(s). Copies of each medical note with work restrictions/limitations needs to be provided with this form.

Date: _____ Dr. Name: _____

Date: _____ Dr. Name: _____

Date: _____ Dr. Name: _____

☐ I do not have a medical documentation at this time, I will provide supporting medical documentation by: _____ (date)

☐ My disability and need for reasonable accommodation in the workplace is/are obvious. Please set up an interactive meeting as soon as possible. I am available the following dates and times to meet:

Date: _____ **/ Time:** _____; **Date:** _____ **/ Time:** _____; **Date:** _____ **/ Time:** _____

☐ At this time I don't have a medical note to support my request for reasonable accommodation. The following are my subjective work restriction/work limitation in need of reasonable accommodation(s):

_____
_____
_____
_____
_____
_____

(d.) ***WHAT IS DURATION OF YOUR ABOVE NOTED WORK RESTRICTIONS / WORK LIMITATIONS?***

☐ **UNKNOWN** ☐ **PERMANENT / LIFETIME** ☐ **UNTIL THE FOLLOWING DATE:** _____

4. ADDITIONAL SUPPORTING DOCUMENTATION

(a.) ***DO YOU HAVE ANY ADDITIONAL INFORMATION: PICTURES, EXAMPLES OF ACCOMMODATIONS, ADDITIONAL SUBJECTIVE WORK RESTRICTIONS OR SUPPORTING DOCUMENTATION THAT MAY BE HELPFUL IN THE REVIEW AND CONSIDERATION OF YOUR REQUEST FOR REASONABLE ACCOMMODATION?*** ☐ **YES, (explain in space below)** ☐ **NO**

(b.) _____ ***(initial) I have received and reviewed the information brochure and I do require accommodation(s) to perform the essential functions of my current position.*** **I have read the following: Disability Under the Fair Employment & Housing Act Pamphlet and DFEH-184 Employment Discrimination Based on Disability.**

I hereby certify that I am disabled as defined by the Federal Americans with Disabilities Act (ADA), California Fair Employment Housing Act (FEHA) and other applicable statues and require reasonable accommodation. I understand that I am required to provide documentation of my disability/medical condition and need for reasonable accommodation. I agree to cooperate fully with this request and throughout the interactive process. I understand that if my request is granted, I am obligated to report any changes to my disability status which may require a re-evaluation of this request. Granting of this request does not signify approval of any future reasonable accommodation request for any other position within my current department or any other department or site within our organization

(c.)

_____ _____

Signature ***Date***