REASONABLE ACCOMMODATION REQUEST FORM

☐ Employee ☐ Program Participant ☐ Candidate for Employment

First Name ___________________________ Last Name ___________________________

Phone Number ___________________________ Email Address ___________________________

Office/Program Area ___________________________ Work location/Building ___________________________

1. My specific functional limitation is: _____________________________________________.

   The accommodation I am requesting is described below.

   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

2. Describe how this accommodation will assist you. Please attach additional sheets as necessary.

   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

EMPLOYEE CERTIFICATION

I certify that I have a medical condition that requires reasonable accommodation, which will be met by acquiring the equipment, services, or work adjustments described above. I give the Department of Economic Opportunity permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act (ADA). This includes permission to obtain relevant medical records. I understand that all information obtained during this process will be maintained and used in accordance with confidentiality requirements.

Signature: ___________________________

(Date)