THE DISABILITY ACCOMMODATION REQUEST FORM

Instructions: The Disability Accommodation Request form must be completed whenever an individual requests an accommodation that would enable him/her to complete the employment process, or perform the essential functions of a position/job.

Part I. Accommodation Request (To be completed by the individual requesting an accommodation)

Name:_____ Employee or
SSN:_____
Home Address:_____ City:_____
Work/Phone:_____ Home Phone:_____
Department Name:_____ Phone:_____
Job Title:_____ Supervisor Name_____
Check Appropriate Category:
_____Current Employee _____ New Hire Candidate: _____ Other

A. I need an accommodation for the reasons listed below: (List the the essential job functions from your job descriptions/ parts of the employment process that cannot be performed without an accommodation)

_____
_____
_____

B. Explain how the limitations affect the ability to successfully complete your job with the County.

_____
_____
_____

C. I am requesting the following accommodation. List possible auxiliary aids, services or alternative methods.

_____
_____
_____

D. Has a physician or other health professional recommended a specific accommodation?
_____ yes _____ no
If yes, please provide documentation.

Part II: Accommodation Process (To be completed by Department Management in collaboration with the requestor)

Check off items as you complete them. Do not skip any item.
___ Confirm the essential functions of the job as distinguished from marginal functions.
___ Determine job related limitations imposed by the disability and identify those that require an accommodation.
___ Contact Human Resources, Commissioners or the County Attorney to help identify internal or external resources to assist in the accommodation process.
___ A meeting was held on_____ between Department Management and the requestor to discuss potential accommodations.
___ The meeting was attended by:_____
___ Review the job description with the requestor to confirm the purpose and essential functions of the job. Attach job description and physical requirement addendum to this form.
___ Consult with the requestor to determine his/her needs and abilities.
___ Identify potential accommodations (equipment/devices needed). Do not eliminate essential job functions in this process,
___ Document the discussion.
_____
_____
_____
_____
_____
_____
___ Proposed accommodations to be submitted to Human Resources for review and Commissioners.
_____
_____
_____
_____
_____
___If accommodation is denied, full explanation of all reasons for denial(I.e. undue hardship, accommodation ineffectual, inadequate medical documentation, accommodation will require elimination of an essential function, accommodation would require reduced performance or production standards, not qualified to apply, poses a direct threat to requestor or others in the workplace, etc.)
_____
_____
_____
_____
_____
_____

Part III. Final Decision (Approval of Commissioners)

_____Approved _____ Denied _____ Modified. If denied or modified, explanation/reason.

_____
_____
_____
_____
_____
_____
_____

Commissioner
Signature_____

Commissioner
Signature_____

Commissioner
Signature_____

The signature below indicates the requestor is in agreement with the accommodation provided.

Requestor
Signature_____

Estimated cost of accommodation_____

Date all modifications made and equipment/devices received_____

Distribution: 1) Human Resources 2) Requestor 3) Department Management 4) Commissioners