AMERICANS WITH DISABILITIES ACT/FAIR EMPLOYMENT AND HOUSING ACT
EMPLOYEE REASONABLE ACCOMMODATION REQUEST

Department: _____ Job Class_____

Name:_____

Home Address:_____

Telephone Number: Work _____Cell or Home_____

Immediate Supervisor:_____

Under State and Federal disability laws, a qualified individual with a disability is one who, with or without a reasonable accommodation, can perform the essential functions of the employment position. Disability is defined as: (a) a physical or mental impairment that limits one or more of the major life activities; (b) a record of such impairment; or (c) being regarded as having such impairment.

*Please submit this form to your supervisor or the EEO Officer in the Personnel Department
If you would like to discuss the request process prior to filing a request, contact the EEO Officer at 454-2935.

EMPLOYEE REQUESTING REASONABLE JOB ACCOMMODATIONS

1. Please list accommodations requested and reason for request:

_____

_____

_____

_____

_____

_____

2. Please attach a completed Physician's Certification for Medical Leave (PER 1081A) **or** Physician's Certification for Return from Medical Leave (PER1086), along with a completed Addendum to Physician's certification (page 2) to this request. Please provide a copy of your job specification with the above forms to your medical health provider.

_____ _____
EMPLOYEE SIGNATURE DATE

ADDENDUM TO PHYSICIAN'S CERTIFICATION

1. Does the patient have a disability as defined by the Americans with Disabilities Act and/or the Fair Employment and Housing Act (i.e., a physical or mental impairment which limits a major life activity)?
   _____ ☐Yes_____ ☐No

   If yes, please describe:

2. Which major life activity does the impairment limit?

3. Please describe how that major life activity is limited.

4. Please describe in detail what accommodation(s) are necessary.

Physician _____Signature _____

Date _____

Address _____