

Accommodation Request Form

Employee Name:	M#	Date (mm/dd/yyyy):
Position Title:	Department:	
Manager:	Length of time required for accommodation(s):	

Please describe the accommodation(s) you believe is needed to enable you to perform the essential functions of your job:

Please describe the nature of your condition(s) and how you believe this condition(s) affect your ability to perform your job responsibilities:

Requests for accommodations should be accompanied by and supported with the *Medical Inquiry Form* signed by your treating physician, psychologist, or other licensed medical provider. It is important for the medical documentation to include length of time the accommodation is needed. Please attach a copy of the medical documentation provided by your physician to this request.

Employee Signature: _____ **Date:** _____

HR USE ONLY

Accommodation to be implemented:

Received by Human Resources: _____ **Date:** _____

HR Designee: _____ **Date:** _____ **Approved**
Denied