Date Received

EMPLOYEE REASONABLE ACCOMMODATION REQUEST FORM

Last Name _____ First Name _____ Last 4 Numbers of Social Security Number _____

Address _____ City _____ Zip _____ Work Phone _____ Home Phone _____

It is the policy of the City and County of San Francisco to provide reasonable accommodations to qualified individuals with disabilities in accordance with the federal Americans with Disabilities Act and the California Fair Employment and Housing Act. You may be required to provide documentation in support of your request for reasonable accommodation.

Please note that this information will be maintained in a separate confidential file from your personnel file and access will be limited only to those with a need-to-know.

1. Current Position:

Class: _____ Title: _____
Dept.: _____ Section: _____

2. Reasonable Accommodation Request:

What type of accommodation do you request?

- ☐ Purchase of assistive device(s)
- ☐ Removal of architectural barrier
- ☐ Reassignment
- ☐ Removal of communications barrier
- ☐ Job Restructuring
- ☐ Other
- ☐ Purchase of assistive services
- ☐ Modified Work Schedule

Please describe the accommodation: (use extra sheets if needed)

Please explain how you believe this accommodation will enable you to perform the essential functions of your position: (use extra sheets if needed)

3. Essential Duties of Your Position:

Please identify the essential duties (do not include marginal duties) of your position for which you are requesting an accommodation:

1. _____
2. _____
3. _____
4. _____

4. Health Care Provider:

Please provide us with the name of your health care provider(s) who can assist with this request: (use extra sheet if needed)

Name: _____
Address: _____
Phone: _____
Specialty: _____

Name: _____
Address: _____
Phone: _____
Specialty: _____

5. Major Life Activities:

Please check the major life activity(ies) you believe to be limited by your medical condition(s):

☐ Walking ☐ Breathing ☐ Seeing ☐ Caring for Oneself ☐ Working
☐ Talking ☐ Hearing ☐ Learning ☐ Performing Manual Tasks ☐ Other:_____

Please describe how the above activity(ies) is/are limited:

6. Is your medical condition temporary? ☐ Yes ☐ No
If yes, please state the expected duration: _____

7. Are you currently working? ☐ Yes ☐ No
If no, please specify the type of leave currently approved: _____
If no, when do you expect to return to work? _____

8. Have you applied previously for a reasonable accommodation within the City?
☐ Yes ☐ No If yes, please explain the status/circumstances:

I hereby certify that I believe I am a qualified individual with a disability as defined by the law. I have received and reviewed the information brochure and require an accommodation to perform the essential functions of my position. I understand that a detailed review of my disability status may be required, and I agree to cooperate fully in this process. I further understand that if my request is granted, I am obligated to report any changes in 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 this department or any other department within the City and County of San Francisco.

_____ _____
Employee Signature Date