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

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