City and County of San Francisco
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Human Resources Director

Department of Human Resources
Connecting People with Purpose
www.sfdhr.org

Commission/Policy Body Member Request for Accommodation

Policy body members are entitled to reasonable accommodations for qualifying disabilities that will enable them to participate fully in meetings where they provide policy leadership and oversight. Pursuant to the City and County of San Francisco's Charter and Administrative Code, and the state Brown Act, policy body members must generally be physically present in the same location for public meetings.

The Department of Human Resources will evaluate accommodation requests from policy body members with qualifying disabilities to make the following determinations: (1) whether the member is a qualified individual with a disability; (2) if so, whether the disability causes limitations that affect the member's ability to perform the essential functions of the member's role in the body; and (3) whether a reasonable accommodation exists that will enable the member to perform all essential functions of the member's role in the policy body. Short-term conditions and minor ailments, such as the flu, headaches, and sprains, are generally not qualifying disabilities because they usually do not limit a major life activity for a significant duration. This form is therefore not intended for non-disabling, short-term conditions.

Please complete this form if you seek accommodations for a qualifying disability. Note that you may be required to provide medical verification in support of your request, and private medical information will be maintained in a confidential file. Access will be limited only to those with a need-to-know.

1. Personal Information

Name:	**Date of Request:**	
Commission/Policy Body:		
Contact Phone:	**Personal Email:**	
Address:		
City:	**State:**	**Zip:**
Commission/Policy Body Secretary:		

2. Type of Accommodation Requested, If Known (Please be as specific as possible, e.g., assistive technology, interpreter, remote attendance, schedule change, etc.)

3. Reason For the Request (What, if any, functions are you having difficulty performing and/or benefits are you having difficulty accessing?)

4. Disability (What limitation is interfering with your ability to perform essential functions of your commission or policy body role?)

5. Specific Information Regarding Condition

Is your disability affecting a major life activity ☐ Yes ☐ No

If yes, what is the major life activity: Check all that apply

☐ Walking	☐ Thinking	☐ Learning	☐ Sleeping
☐ Speaking	☐ Sitting	☐ Performing Manual Tasks	☐ Working
☐ Breathing	☐ Standing	☐ Caring for Self	☐ Reproduction
☐ Hearing	☐ Reaching	☐ Concentrating	☐ Eating
☐ Seeing	☐ Interacting with Others	☐ Lifting	☐ Bowel/Bladder Control

☐ Other (describe):

6. Duration of Disability

Is your disability temporary?

☐ Yes (specify the estimated duration, e.g. "through 7/31/2023," "6 months," "until completion of therapy," etc.): _____

☐ No, my condition is permanent

7. For Policy Body Members Seeking Remote Participation at Meetings

Please select your proposed remote location for meeting participation:

☐ Home address

☐ Other (specify): _____

Please select all technologies that are available to facilitate remote participation at your selected location:

☐ Secure Internet Connection	☐ Apps/Software for Online Meetings
☐ Computer/Laptop with Video & Audio	☐ Teleconference Equipment
☐ Computer/Laptop with Audio-only	☐ Smartphone with Video Capability

8. Medical Verification/Documentation

Please provide the name of your health care provider who can assist the City with evaluating this request:

Name: _____

Address:_____

Phone: _____

We will only contact your health care provider if necessary and with your express written consent.

I hereby certify that to the best of my knowledge, the information I have provided above is true and accurate. I understand that a detailed review of my request is 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 status which may require a re-evaluation of this request.

_____ _____

Signature Date