City and County of San Francisco
Carol Isen
Human Resources Director

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

Employee Request for Reasonable Accommodation

Name: ________________________________DSW#: _______________Class/Title: _____________

Address: ______________________________City:__________________ State: _____ Zip: ________

Contact No.: ______________________________ Personal Email: _________________________________

Dept.: ____

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 (ADA) and the California Fair Employment and Housing Act (FEHA). 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.

I. Reasonable Accommodation Request:

☐ Purchase of assistive device(s) ☐ Removal of communications barrier ☐ Job Restructuring

☐ Purchase of assistive services ☐ Removal of architectural barrier ☐ Modified Reassignment

☐ Other (specify): ____

Please describe the accommodation: (use extra sheets if need) ________________________________

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II. 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. ____

III. Health Care Provider:

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

Name: ____

Address: ____

Phone: ____

Specialty: ____

Health Care Provider (Additional):
Name: ____
Address: ____
Phone: ____
Specialty: ____

IV. Major Life Activities:

Please check the major life activity/activities 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 described how the above activity/activities is/are limited: _______________________________

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a. Is your medical condition temporary? ☐ Yes ☐ No

If yes, please stated the expected duration: ____

b. Are you currently working? ☐ Yes ☐ No

If no, please specify the type of leave currently approved and the duration (dates):

____

c. Have you previously applied for a reasonable accommodation within the City? ☐ Yes ☐ No

If yes, please explain the status/circumstances: ____

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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