STAFF REQUEST FOR REASONABLE ACCOMMODATION

DATE _____

NAME _____ PHONE _____

ADDRESS_____ CITY _____ ZIP _____

POSITION _____ SUPERVISOR _____

DESCRIPTION OF DISABILITY _____

_____

_____

ACCOMMODATION REQUESTED

ACCESS TO FACILITY OR PROGRAM:

_____

_____

JOB RESTRUCTURING/MODIFICATION:

_____

_____

EQUIPMENT:

_____

_____

OTHER:

_____

_____

_____

_____
SIGNATURE of STAFF MEMBER

_____
SIGNATURE of ATTENDING PHYSICIAN