CS-1668
REV 11/2023

DISABILITY ACCOMMODATION REQUEST AND MEDICAL STATEMENT

SECTION I: FOR COMPLETION BY OR ON BEHALF OF EMPLOYEE. You may, but are not required, to use this form to request a reasonable accommodation. If you request a reasonable accommodation and chose to not complete this form, your agency's Reasonable Accommodation Coordinator may contact you to gather this information. If you choose to complete this form, please answer each item in Section I and return it to your agency's Accommodation Coordinator or other designated official. The Accommodation Coordinator or other designated official may request additional information allowed by law as part of the interactive process. For further information, refer to Civil Service Regulation 1.04, "Reasonable Accommodation." The Reasonable Accommodation Coordinator or other designated official will notify you if the information in Section II is needed. Notification of approval or disapproval will be provided in writing.

1. Name	**2. Employee Identification Number**	**3. Employing Agency**
4. Working Title	**5. Civil Service Classification**	**6. Bargaining Unit**
7. Work Address (home address if on leave)		**8. Telephone Numbers** Work Home

9. Describe any accommodations requested as specifically as possible or, if you are not sure what accommodation is needed, any suggestions about what options can be explored.

10. Describe any job functions you are having difficulty performing or benefits and privileges of employment you are having difficulty accessing, if any.

11. Describe any functional limitations that are interfering with your ability to perform your job or access an employment benefit. Use additional pages, if necessary.

12. Have you had any accommodations in the past for this same limitation? ☐ ☐

13. If *yes*, what were the accommodations and how effective were they?

14. Please provide any additional information that might be useful in processing your accommodation request?

15. Immediate supervisor's name and phone number	**16. Employee's Signature**	**17. Date Submitted**

SECTION II: FOR COMPLETION BY MEDICAL PROVIDER IF REQUESTED BY EMPLOYER. This section should be signed by an employee's medical or health care provider.

Instructions for the Medical or Health Care Provider: An individual has a disability under the ADA if they have a physical or mental impairment that substantially limits one or more major life activities or have a record of such an impairment. The following may help us determine your patient's eligibility for a reasonable accommodation under the ADA because of a disability. Please fully answer all applicable parts, based on your medical knowledge, experience, and examination of this patient. Please review the patient's position description before completing this form. Please attach additional sheets if needed. When completed, please sign and return the form to the patient to submit to their employer.

1. Health Care Provider's Name, Specialty, and Business Address	**2. Telephone Number**

3. Does the employee have a physical or mental impairment? Yes☐ No☐

4. If *Yes*, what is the impairment?

5. Does the impairment substantially limit a major life activity as compared to most people in the general population? Yes☐ No☐	**6. If *Yes*, what major life activities or bodily functions are affected?**

7. What limitations interfere with job performance or accessing a benefit of employment?

8. What job functions or benefits of employment are the employee limited in performing or accessing because of the limitations?

9. How do the limitations interfere with the employee's ability to perform a job function or access a benefit of employment?

10. What is the duration or expected duration of the employee's impairment?

11. List any suggestions you have regarding possible accommodations. If medical leave is one of the possible accommodations, please provide an estimated duration for the leave.

12. Would performing any job function listed in the job description result in a direct threat to the health or safety of the employee or other people? ☐ Yes ☐ No

13. If *Yes*, (a) which job functions would pose a threat, (b) what is the nature of the threat, and (c) is there any reasonable accommodation that would eliminate or reduce the threat to an acceptable level?

(a)

(b)

(c)

14. Medical Provider's Signature	**15. Date**

DISABILITY ACCOMMODATION REQUEST AND MEDICAL STATEMENT

INSTRUCTIONS FOR COMPLETING THE DISABILITY ACCOMMODATION REQUEST FORM

(Consult your agency's accommodation coordinator or other designated official for assistance, if necessary.)

Section I	Instructions
Questions 1-8	Complete all personal information that is applicable.
Question 9	Describe the accommodations you are requesting. Please provide alternative accommodation suggestions, where possible.
Question 10	Describe the job functions you are having difficulty performing or employment benefits you are having difficulty accessing, if any. "Benefits and privileges of employment" include employer-sponsored: (1) training, (2) services, and (3) parties or other social functions.
Question 11	Describe the functional limitations that interfere with your ability to perform your job or access an employment privilege or benefit.
Questions 12 and 13	Indicate whether you have previously been granted an accommodation for this same limitation, and if so what the accommodation was and describe its effectiveness.
Question 14	Provide any other information that you believe would be helpful in explaining your need for a reasonable accommodation
Questions 15 through 17	Indicate your immediate supervisor's name and phone number and sign and date the form.

FILING BY EMPLOYEE

Once Section I is completed, make and save a copy of it. Submit the signed original to your agency's accommodation coordinator or other designated official.

INTERACTIVE PROCESS AND ADDITIONAL DOCUMENTATION

Your agency's accommodation coordinator or other designated official will, if necessary, engage in an interactive process under the ADA to determine an appropriate accommodation. If additional documentation or medical information is necessary to determine that you have a disability under applicable state and federal law (including the Americans with Disabilities Act or "ADA") and need a reasonable accommodation, your agency's accommodation coordinator or other designated official may request that you have your medical or healthcare provider complete Section II. Your agency's accommodation coordinator or designated official should provide you with your position description to give to your healthcare provider, which will assist them in completing Section II. If required, return the completed Section II to your agency's accommodation coordinator or designated official.

RESPONSE TIME

Your agency may offer temporary measure(s) until a final decision can be made. You should receive a final response to a request within eight weeks. If necessary, follow up with your accommodation coordinator or other designated official.

APPEAL

If you are dissatisfied with the final response of the accommodation coordinator or the accommodation coordinator fails to issue a final response within eight weeks, you may appeal through the appropriate agency process, grievance procedure, or take other action as authorized by law.

CONFIDENTIALITY

Information in your request will be held confidential to the extent possible consistent with state and federal law.