A-1

DEPARTMENT OF EMPLOYEE RELATIONS

Issue Date: October 2015; Updated August 24, 2021

APPENDIX C

DISABILITY ACCOMMODATION OR MEDICAL EXEMPTION REQUEST FORM

Part 1: To be completed by employee and submitted to Personnel Officer or manager

Name: _____ Department/Division: _____

Date of request: _____

Supervisor: _____

My disability impairs my ability to perform assigned job duties in the following way (attach additional pages if necessary):

_____

_____

_____

My medical condition prevents me from completing a condition of employment, such as receiving a vaccination in the following way (attach additional pages if necessary):

_____

_____

_____

The reasonable accommodation(s) I am requesting are (attach additional pages if necessary):

_____

_____

_____

Alternatives I seek are:

_____

_____

_____

Employee signature: _____ Date: _____

Part 2: To be completed by the employee's Personnel Officer or manager

Date of interactive meeting(s): _____

Date documents were reviewed: _____

Accommodation Request is: ☐Approved ☐Denied ☐ Modified

If modified, describe modification and give rationale. If denied, give rationale. (Attach additional pages if necessary.)

_____

_____

Alternatives suggested:

_____

_____

Cost of Accommodation: _____ ☐ Estimate ☐ Actual

Name of other departmental/DER representative consulted with:
_____ Date: _____

Immediate supervisor: _____ Date: _____

Manager or Department Head: _____ Date: _____

Personnel Officer: _____ Date: _____

The employee may submit additional information, documentation, alternative suggestions or requests at any time, including after this form has been completed