Print Form

ALAMEDA COUNTY
REQUEST FOR REASONABLE ACCOMMODATION
(Employee)

Alameda County provides equal employment opportunities and reasonable accommodation to qualified individuals with disabilities consistent with relevant federal, state, and local laws. A reasonable accommodation is any appropriate measure that would allow an employee with a disability/medical condition to perform the essential job functions unless the accommodation would present an undue hardship to the business operation. Pursuant to the County's Reasonable Accommodation Policy, we are committed to assisting employees in identifying an appropriate accommodation through a good-faith interactive process. Specific information must be ascertained in order to establish that a disability/medical condition exists and to determine a potential accommodation that would enable the employee to perform the essential job functions.

Notice to Employees: This form and the information contained within are strictly confidential and will be maintained in a separate confidential file from your personnel file. The information provided will only be used to determine a potential and appropriate accommodation necessary for you to perform the essential job functions. Access will be limited only to those with a need-to-know basis. For more information, contact your agency/department human resources office or designated disability coordinator.

Please complete the information below, sign and return to the requestor.

Name: _____ **Employee ID#:** _____

Date: _____ **Job Title:** _____

Work Phone: _____ **Home/Cell Phone:** _____

Agency/Department: _____ **Division/Work Unit:** _____

Supervisor's Name: _____

(Please check all that apply)

☐ I have a disability/medical condition that requires reasonable accommodation

☐ My disability/medical condition is permanent

☐ My disability/medical condition is temporary and is expected to last until: _____

☐ My disability/medical condition arose from an industrial injury. Date of Injury: _____

Please describe the part of your job that requires accommodation, or work environment that is a barrier or obstacle to you. Also, describe how your disability/medical condition limits your ability to perform the essential functions of your job or otherwise receive treatment equal to that provided to other employees (be specific):

If you know the accommodation needed, please describe your requested accommodation:

Please describe how this accommodation will assist you in performing the essential job functions of your position or be provided the same opportunities available to other employee:

- ○ I have attached my physician/clinician statement verifying my disability/medical condition and the need for the accommodation requested.
- ○ I will provide my physician/clinician statement verifying my disability/medical condition and the need for the accommodation requested by (date): _____

EMPLOYEE CERTIFICATION

I hereby certify that I am disabled as defined by the Federal Americans with Disabilities Act (ADA), California Fair Employment and Housing Act (FEHA) and other applicable statutes and require reasonable accommodation. I understand that I am required to provide documentation of my disability/medical condition and need for reasonable accommodation. I agree to cooperate fully with this request and throughout the interactive process. I am aware that if at any point it is determined or revealed that at the time I submitted my request or participated in the reasonable accommodation process I did not have a disability/medical condition; it may result in disciplinary action up to and including dismissal from employment with Alameda County.

Signature: _____ Date: _____

Return to:

For Office Use Only

Accommodation employee requested (be specific):

Accommodation(s) considered/offered:

Accommodation agreed upon:

Employee response (i.e. accepted, refused, and negotiated) and reason, if refused:

List any agencies contacted to implement this request (include phone number and response):

HR Analyst/Personnel Officer/Disability Coordinator: _____

Date: _____ Date letter sent: _____ Date STARS data completed: _____

Reviewed by: _____ Date: _____
