REQUEST FOR REASONABLE ACCOMMODATION (ADA)

RETURN THIS FORM TO PCS: HUMAN RESOURCES

ATTENTION: ADA *EMAIL: PCSLEAVES@PCSB.ORG* OR FAX: (727) 588-5001

301 4TH ST. SW LARGO, FL 33770

EMPLOYEE NAME:	LAST 4 SSN:
EMPLOYEE NUMBER:	FOR HR PURPOSES:
WORK SITE:	DATE RECEIVED:
CURRENT POSITION:	MEDICAL DOCUMENTATION REQUESTED:
DATE:	

DIRECTIONS: Please complete this two (2) page form in its entirety. If needed, attach any additional information. Please type or print in blue or black ink.

1) IDENTIFY YOUR DISABILITY OR PHYSICAL OR MENTAL IMPAIRMENT(S) OR LIMITATIONS(S) ("DISABILITY"):

2) EXPLAIN HOW YOUR DISABILITY IMPAIRMENT(S) LIMIT YOUR ABILITY TO PERFORM YOUR ASSIGNED JOB DUTIES:

3) EXPECTED DURATION OF DISABILITY:

4) WHAT SPECIFIC ACCOMMODATION(S) ARE YOU REQUESTING, IF KNOWN?

5) IF YOU ARE NOT SURE WHAT ACCOMMODATION IS NEEDED, DO YOU HAVE ANY SUGGESTIONS ABOUT WHAT OPTIONS WE CAN EXPLORE? IF YES, PLEASE EXPLAIN.

6) IF YOU ARE REQUESTING A SPECIFIC ACCOMMODATION(S), HOW WILL THAT ACCOMMODATION(S) ASSIST YOU TO PERFORM YOUR JOB DUTIES?

7) HAS A HEALTH CARE PROFESSIONAL RECOMMENDED A SPECIFIC ACCOMMODATION? DESCRIBE OR ATTACH DOCUMENTATION.

8) IF NEEDED, HUMAN RESOURCES MAY REQUEST ADDITIONAL INFORMATION FROM YOUR MEDICAL PROVIDER TO DETERMINE ACCOMMODATION NEED/ELIGIBLITY. PLEASE PROVIDE YOUR PHSYCIAN'S NAME, ADDRESS, PHONE NUMBER, AND FAX NUMBER.

9) PROVIDE ANY ADDITIONAL INFORMATION THAT MIGHT BE USEFUL IN PROCESSING YOUR ACCOMMODATION REQUEST.

10) IS YOUR ACCOMMODATION REQUEST TIME SENSITIVE? IF YES, PLEASE EXPLAIN.

11) HAVE YOU HAD ANY ACCOMMODATIONS IN THE PAST FOR THIS SAME LIMITATION? IF YES, WHAT WERE THEY AND HOW DID THE ACCOMMODATION(S) HELP YOU PERFORM YOUR JOB DUTIES?

THIS INFORMATION IS TREATED CONFIDENTIALLY, IS NOT MAINTAINED IN THE EMPLOYEE'S MAIN PERSONNEL FILE, AND WILL BE USED ONLY BY AUTHORIZED INDIVIDUALS WITH DIRECT NEED TO KNOW TO DETERMINE REASONABLE ACCOMMODATION.

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