REASONABLE ACCOMMODATION REQUEST FORM

Name:_____

Address:_____
Street Apt. # City State Zip

Telephone:_____ Email:_____

REQUEST FOR REASONABLE ACCOMMODATION

1. I am requesting accommodation because (circle one): **A or B**

(A) I am applying for employment. The accommodation requested will allow me to participate in the application process for the following position:

_____

(B) I am currently employed by the **Town of Sandwich** and request a reasonable accommodation. My current job title is:

_____

2. My specific functional limitation is: _____
The accommodation I am requesting is described below. (Describe the type of accommodation; if it is a purchasable item, list model, number, cost, where it can be obtained, etc. suggestions for work site or examination site modifications or specific job duties which may be restructured or shared to facilitate employment). Please attach additional sheets as necessary.

_____

_____

_____

3. Describe how this accommodation will assist you. Please attach additional sheets as necessary.

_____

_____

_____

EMPLOYEE CERTIFICATION

I certify that I have a disability or medical condition that requires reasonable accommodation, which will be met by acquiring the equipment, services or work adjustments described above.

Signature:_____**Date:**_____

REQUEST FOR MEDICAL INFORMATION FOR REASONABLE ACCOMMODATION

Date:_____
To:_____
From: Human Resources Department – Town of Sandwich
Re: Request for medical information needed to assist in providing a reasonable accommodation for:

_____	_____	_____
(Applicant/Employer)	**(Medical Record #)**	**(Social Security #)**

The Town of Sandwich is attempting to provide reasonable accommodation to the Applicant/Employee indicated above. The information requested below is confidential and will only be used to determine the specific equipment and/or services necessary to accommodate the identified limitations due to the verified disability. Page 4 is the Authorization from this individual to release this medical information. Please take the below definition into consideration and answer the following questions with respect to applicant/ Employee's request for reasonable accommodation:

1. Does the individual have an impairment that limits a major life activity? **Yes___ No___**

   If yes, please see page 3 of this form to describe the limitation.

2. Is the disability permanent? **Yes___ No___.** Length of anticipated duration:_____

3. From the enclosed job description, specify the job duty that the employee cannot perform

   _____
   _____
   _____

4. How does the limitation(s) impair the ability of the Applicant/Employee to perform the job duty described above?

   _____
   _____
   _____
   _____

Under the Americans with Disabilities Act, and individual with a disability is a person who: (1) has a physical or mental impairment that substantially limits one or more major life activities (major life activity may include walking, breathing, speaking, performing manual task, seeing, hearing, learning, caring for oneself, sitting, standing, lifting or reading); (2) has a record of such an impairment; or (3) Is regarded as having such an impairment.

PHYSICIAN'S SIGNATURE:_____
DATE_____PHONE:_____

Instructions: complete this side of the form only if the answer to question #1 is yes.

_____ _____

(Applicant/Employee Name) **Date**

☐ KEYBOARD USE/REPETITIVE USE OF HANDS	☐ GRASP/FINE FINGER MOTIONS
☐ SIT	☐ REPETITIVE USE OF FOOT CONTROLS
☐ STAND	☐ WALK
☐ SQUAT/KNEEL	☐ TWISTING (NECK/WAIST)
☐ BEND/STOOP	☐ CLIMB LADDERS/CLIMB STAIRS
☐ PUSH/PULL	☐ REACHING (Above and below shoulders)
☐ LIFT (Please specify lifting restriction)	
☐ CARRY (Please specify carrying restriction)	
☐ OTHER	
Describe any restrictions which may apply to the following:	
☐ VISION	
☐ HEARING	
☐ MENTAL/EMOTIONAL	
☐ OTHER (Sleeping, Speaking)	

AUTHORIZATION FOR RELASE OF MEDICAL INFORMATION

TO: My Medical Care Provider(s)

You are hereby authorized to give to the **Town of Sandwich Human Resources Department** all information, facts and particulars, including reports, records, results from diagnostic tests, x-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability or recommendations for further treatment and to furnish them copies of such reports.

This information is to be used for purposes of evaluating and handling my claim and for no other purpose, now or in the future.

_____

SIGNATURE

_____

DATE