APPENDIX A

ACCOMMODATION REQUEST FORM

Name:	Date:
Signature:	Department:

1. What specific accommodation are you requesting?

2. If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? ☐ Yes ☐ No

3. If yes, please explain.

4. Is your accommodation request time sensitive? ☐ Yes ☐ No

5. If yes, please explain.

6. What, if any, job function are you having difficulty performing?

7. What, if any, employment benefit are you having difficulty accessing?

8. What limitation is interfering with your ability to perform your job or access an employment benefit?

9. If you are requesting a specific accommodation, how will that accommodation assist you?

Please provide/attach any additional information that might be useful in processing your accommodation.

RETURN THIS COMPLETED FORM TO HUMAN RESOURCES

1340 State Route 9, Lake George , NY 12845 – Fax 518-761-6509

APPENDIX A

ACCOMMODATION REQUEST FORM

I, _____, understand that I am giving permission to the Warren County Human Resources and/or Self-Insurance Departments to contact the following individual(s) for purposes of requesting documentation/information regarding my disability including the diagnosis and limitations associated with that diagnosis.

I understand that this permission will remain in effect from the day I sign this document until I revoke permission in writing or am no longer affiliated with Warren County.

Provider Name:	
Address:	
Phone:	Fax:

Provider Name:	
Address:	
Phone:	Fax:

Provider Name:	
Address:	
Phone:	Fax:

I understand that communication with the above names individual(s) will not include personal disclosures that so not pertain to my disability(ies). I understand that all medical information related to my request for accommodation is confidential and will be maintained in a secured location within the Human Resources Department separate and apart from my personnel file. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of functional limitations on my ability to perform the essential functions of my job.

_____ _____

Signature Date

RETURN THIS COMPLETED FORM TO HUMAN RESOURCES

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