REASONABLE ACCOMMODATION REQUEST FORM

The purpose of this form is to assist the College in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of his or her job safely and effectively. This form must be filed separately from the employee's personnel file and be treated confidentially.

SECTION I: Employee Completes This Section (Please Print or Type)

| Name | | |
|----------------------|---|------------------------------|
| (Last) | (First) | (Middle) |
| Job Title: | Department: _ | |
| Address: | | |
| | | |
| Home Phone #: | E-Mail: | |
| | | |
| reasonable accommoda | College, Office of Human Resources, permission ations under the Americans with Disabilities Acturing this process will be maintained and used in equirements. | . I understand that all |
| Form giving Lewis & | at I am required to complete and sign the Employ Clark College permission to consult with my hea qualified employee with a disability and to seek g ased on my disability. | alth care professional(s) to |
| Data: | Employee's Signature | |

What are the current limitations caused by your condition(s)? Given these limitations, what parts of your assigned job duties are impeded by your condition? To get us thinking about an effective accommodation, tell us what changes you suggest related to how you perform your job or the actual duties to make it possible for you to continue to do your job well.

Please answer the following questions to assist us in understanding the basis and nature of

your request for an accommodation (attach additional sheets if necessary).

Has the employee signed the Reasonable Accommodation Request Form? ____ yes ____ no Have the essential functions of the position been discussed and confirmed? ____ yes ____ no Which of the following has the employee been given to take to his or her doctor(s)? ____ Signed Employee Disability Verification Form Job Description ___ Cover Letter ____ Other Supporting Documentation or Information (please describe) Date Section II complete: Section II completed by (name): SECTION III: To be completed by ADA Coordinator or designee after receiving documentation from health cares provider(s). Is the health care provider documentation sufficient for the College to determine if the employee has a physical or mental impairment that substantially limits one or more major life activities and the employee's ability to perform the essential job functions? ___ yes ___ no If no, list date when sufficient documentation was received: Date: If yes, doctor's recommendation about a possible accommodation: List contacts with employee after the health care documentation was received. Outcome of conversation:

SECTION II: To be completed by the ADA Coordinator or designee.

| Date: | |
|--------------------------------|---------------------------------|
| Outcome of conversation: | |
| | |
| | |
| Other contacts. Dates and outc | comes of those conversations: |
| Other contacts. Dates and out | comes of those conversations. |
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| | |
| Is the employee disabled as de | fined by the ADA? yes no |
| Is the employee otherwise qual | lified for the position? yes no |
| List specific accommodation(s | discussed and/or approved: |
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| | |
| Name of person completing fo | rm: |
| Phone: | Date form was completed: |
| Estimated cost of accommodat | tion if known: |
| Revised 12/02 | |