Employee Request for Accommodation Form

The purpose of this form is to assist The Department of Military in determining whether, or to what extent, a reasonable accommodation for an employee with a disability is required to perform one or more essential functions of their job safely and effectively. The employee must initiate this request for an accommodation. The information will be treated confidentially. To be eligible for a reasonable accommodation under the Americans with Disabilities Act, you must be qualified to perform the essential functions of your position with or without an accommodation, and have a qualifying disability that limits a major life function.

If a disability and/ or need for reasonable accommodation is not obvious or already on file with the Department, the Department has a right to request medical documentation to substantiate the disability and the requested accommodation. If you have been asked to provide any medical information, you must have your physician to complete the DOM Medical Review Form, submit it with this form, unless it has already been provided.

Date of Request: _____

Employee Information	Supervisor's Information
Name:	Name:
Work Location:	Work Location:
Personnel Number:	Personnel Number:
Job Title:	ML Area:

1. Name and Title of person that initially received this request (supervisor, chain of command, HR Representative, EEO Officer):

2. Please briefly describe the medical condition requiring accommodation:

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3. List specifically what type of accommodations are you requesting (*Be as specific as possible, e.g., adaptive equipment, reader, interpreter, etc., or performing job duties.):*

I give DOM permission to explore possible coverage and reasonable accommodations under the Americans with Disabilities Act of 1990 as amended. I understand all information obtained will be used in accordance with ADA confidentiality requirements:

Employee's Signature: _____ Date: _____

******************************DOM HR ONLY************************

Accommodation request is (please circle one): Approved Denied Modified

If modified, describe modification. If denied, give justification.

HR Administrator's Signature: _____ Date: _____