REASONABLE ACCOMMODATION REQUEST FORM (option 1)

NAME JOB

STORE

THIS FORM SHOULD BE COMPLETED WHEN AN EMPLOYEE HAS INDICATED HIS OR HER DESIRE TO REQUEST A REASONABLE ACCOMMODATION FROM THE COMPANY. UPON COMPLETION, THIS FORM MUST BE DELIVERED TO PERSONNEL AND KEPT SEPARATE FROM THE EMPLOYEE’S PERSONNEL FILE.

**THE PURPOSE OF THIS FORM IS TO ASSIST THE COMPANY IN DETERMINING WHETHER OR TO WHAT EXTENT A REASONABLE ACCOMMODATION IS REQUIRED FOR AN EMPLOYEE TO PERFORM THE ESSENTIAL FUNCTIONS OF HIS OR HER JOB SAFELY AND EFFECTIVELY.**

TO BE COMPLETED BY THE EMPLOYEE

1. IDENTIFY AND DESCRIBE THE PHYSICAL OR MENTAL DISABILITY ILLNESS, CONDITION, OR DISEASE THAT IS THE BASIS FOR YOUR REQUEST FOR REASONABLE ACCOMMODATION(S) BY THE COMPANY:

 *{SEE DEFINITION OF “DISABILITY” ON REVERSE SIDE}.*

1. IDENTIFY AND DESCRIBE THE ESSENTIAL FUNCTION(S) OF YOUR JOB THAT YOU ARE UNABLE TO PERFORM WITHOUT REASONABLE ACCOMMODATION(S) BY THE COMPANY:

 *{SEE DEFINITION OF “REASONABLE ACCOMMODATION” ON REVERSE SIDE}.*

1. IDENTIFY AND DESCRIBE THE REASONABLE ACCOMMODATION(S) NEEDED TO ENABLE YOU TO PERFORM THE ESSENTIAL FUNCTIONS OF YOUR JOB PROPERLY AND SAFELY, INCLUDING SPECIAL EQUIPMENT, CHANGES IN THE PHYSICAL LAYOUT OF THE JOB, OR OTHER ACCOMMODATIONS:

1. IDENTIFY AND DESCRIBE ANY SPECIAL METHODS, SKILLS, OR PROCEDURES THAT WOULD ENABLE YOU TO PERFORM THE ESSENTIAL FUNCTIONS OF YOUR JOB:

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1. IDENTIFY AND DESCRIBE ANY EQUIPMENT, AIDS, OR SERVICES THAT YOU ARE WILLING TO PROVIDE AND UTILIZE:

1. IDENTIFY THE NAMES AND ADDRESSES OF PHYSICIANS, THERAPISTS, PSYCHOLOGISTS, OR OTHER HEALTH-CARE PROVIDERS WHO HAVE INFORMA­TION OR DOCUMENTATION CONCERNING YOUR DISABILITY, ILLNESS, CONDITION, OR DISEASE OR YOUR NEED FOR A REASONABLE ACCOMMODATION BY THE COMPANY:

I HEREBY AUTHORIZE THE ABOVE-LISTED HEALTH-CARE PROVIDERS AND ANY OTHERS WHO HAVE TREATED ME TO RELEASE TO {COMPANY NAME} ALL MEDICAL RECORDS CONCERNING THE DISABILITY DISCLOSED HEREIN AND PROVIDE ANY OPINIONS TO {COMPANY NAME} CONCERNING MY ABILITY TO PERFORM JOB-RELATED FUNCTIONS WITH OR WITHOUT REASONABLE ACCOMMODATION.

I CERTIFY THAT I HAVE READ AND REVIEWED THE JOB DESCRIPTION FOR MY JOB OR POSITION AND/OR BEEN INFORMED OF THE ESSENTIAL FUNCTIONS OF MY JOB. I FURTHER CERTIFY THAT THE FOREGOING STATEMENTS ARE COMPLETE, ACCURATE, AND TRUE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT A MISSTATEMENT OR OMISSION OF FACT MAY BE CAUSE FOR DISMISSAL. I ALSO UNDERSTAND THE COMPANY MAY REQUIRE ME TO UNDERGO TESTING OR EVALUATION BY MEDICAL PERSONNEL RETAINED BY THE COMPANY FOR THE PURPOSE OF ESTABLISHING THE EXISTENCE AND EXTENT OF MY DISABILITY, ILLNESS, CONDITION, OR DISEASE AND MY ABILITY TO PERFORM JOB-RELATED FUNCTIONS WITH OR WITHOUT REASONABLE ACCOMMODATION.

EMPLOYEE’S SIGNATURE: DATE:

 “**DISABILITY**” INCLUDES A PHYSICAL OR MENTAL IMPAIRMENT THAT SUBSTANTIALLY LIMITS ONE OR MORE MAJOR LIFE ACTIVI­TIES. MAJOR LIFE ACTIVITIES INCLUDE SUCH THINGS AS CARING FOR ONESELF, PERFORMING MANUAL TASKS, WALKING, SITTING, STANDING, LIFTING, REACHING, SEEING, HEARING, BREATHING, LEARNING, AND WORKING.

“**REASONABLE ACCOMMODATION**” INCLUDES ANY MODIFICATION TO THE JOB OR WORK ENVIRONMENT TO ENABLE AN ASSO­CIATE TO PERFORM THE ESSENTIAL FUNCTIONS OF THE JOB IN QUESTION.

THESE DEFINITIONS ARE PROVIDED ONLY AS A GUIDE FOR COM­PLETING THIS FORM. NOTHING IN THIS FORM IS INTENDED TO ALTER THE LEGAL DEFINITIONS OF THESE TERMS OR IMPOSE OBLIGATIONS ON THE COMPANY NOT REQUIRED BY LAW.

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