



REQUEST FOR REASONABLE ACCOMMODATION

Employee Questionnaire

Please return completed form to Office of Human Resources

Date	
Name	
Department	
Email address	
Position title	
Phone numbers (home, office and cell)	
Home address	
Supervisor's Name	

Please complete the following:

1. What, if any, position function are you having difficulty performing?
2. What, if any, employment benefit are you having difficulty accessing?
3. What limitation(s) is interfering with your ability to perform your job or access an employment benefit? Have you had any accommodations in the past for this same limitation? NO YES If yes, what were they and how effective were they?
4. Is there any additional information that you would like the District to be aware of that may assist in this process. Please do not provide any information on your diagnosis, condition or treatment.

I certify that the above is true and accurate.

Employee's Original Signature

Date

Received

Signed

Print Name

Date Received