

## REASONABLE ACCOMMODATION REQUEST FORM

NAME \_\_\_\_\_

POSITION APPLYING FOR/HOLDING \_\_\_\_\_

DEPARTMENT \_\_\_\_\_ SUPERVISOR \_\_\_\_\_

This form should be completed when an applicant or employee has indicated his or her desire to request a reasonable accommodation from the County. Upon completion, this form must be delivered to Human Resources and kept separate from the applicant's/employee's personnel file.

The purpose of this form is to assist the County in determining whether or to what extent a reasonable accommodation is required for an applicant/employee to safely and effectively perform the essential functions of his or her present job or the job he/she is seeking.

### TO BE COMPLETED BY THE APPLICANT/EMPLOYEE

1. Identify and describe the physical or mental disability, illness, condition or disease which is the basis for your request for reasonable accommodation(s) by the County (see definition of "disability" on the reverse side):

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2. Identify and describe the essential function(s) of your job or the job you are seeking which you are unable to perform without reasonable accommodation(s) by the County (see definition of "reasonable accommodation" on reverse side):

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3. Identify and describe the reasonable accommodation(s) needed to enable you to properly and safely perform the essential functions of your job or the job you are seeking, including special equipment, changes in the physical layout of the job, or other accommodations:

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4. Identify and describe any special methods, skills or procedures which would enable you to perform the essential functions of your job or the job you are seeking:

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5. Identify and describe any equipment, aids, or services that you are willing to provide and utilize:

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6. 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 County:

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I hereby authorize the above-listed health care providers and any others who have treated me to release to the Montgomery County Human Resources Department information concerning the disability disclosed herein and provide any opinions to them concerning my ability to perform essential job-related functions with or without reasonable accommodation.

I certify that I have read and reviewed the job description for my job or the job I am seeking and/or have 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 the County may require me to undergo testing or evaluation by medical personnel retained by the County for the purpose of establishing the existence and extent of my disability, illness, condition, or disease and my ability to perform essential job-related functions with or without reasonable accommodation.

Applicant's/Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

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“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 County not required by law.

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