

**AMERICANS WITH DISABILITIES ACT
EMPLOYEE REASONABLE ACCOMMODATION REQUEST**

Department: _____ Job Class _____

Name: _____

Address: _____

Immediate Supervisor:

Telephone Number: Work _____ Home _____

An individual is protected under the ADA if the individual is a qualified individual with a disability who, with or without reasonable accommodations, can perform the essential functions of the employment position. Disability is defined, with respect to an individual, as: (a) a physical or mental impairment that limits one or more of the major life activities of such individual; (b) a record of such an impairment; or (c) being regarded as having such an impairment. (Note: Under federal ADA laws an impairment must substantially limit a major life activity. State law will be applicable for California, requiring that an impairment must limit a major life activity).

*Please submit this form to Immediate Supervisor

PART I: EMPLOYEE REQUESTING ACCOMMODATIONS

1. Please list accommodations requested and reason for request:

2. A completed PER1081A Physician's Statement for Medical Leave or Return from Medical Leave must be attached to this request. You must attach a copy of your job specification with the PER1081A to your Physician as required by the ADA.

SIGNATURE _____ DATE _____