JAYNOLAN community services

Accessibility and Accommodation Request Form

Name:	Job Title:
Department #:	Request Date:

1. Which condition below is related to your work accommodation/modification?

- ○ Disability
- ○ Medical Condition
- ○ Religion
- ○ Other (please specify): _____

2. What is the expected duration/time period for this work accommodation/modification:

_____

Please describe work accommodation/modification you are requesting and purpose for request.
Medical documentation from your care provider will be required to accommodate any medical accommodation requests:

Employee Name: _____ Supervisor Signature: _____

Employee Signature: _____ Date: _____

EMPLOYER SECTION

Accommodation/Modification request is: **Approved** ☐ **Denied** ☐

Name of HR Administrator making decision:

Name: _____ Job Title: _____

Signature: _____ Date: _____

If approved, indicate what work accommodation/modification will be provided and the duration below:

If denied, check reasons for denying the work accommodation/modification request.
You may check more than one:

☐ The individual did not provide documentation of a disability that substantially limits physical activity.

☐ The requested accommodation is ineffective. It will not enable individual to perform the essential functions of the position.

☐ The individual's disability/limitations do not prevent him/her from performing the essential functions of the position. The accommodation request will:

- ☐ Create an undue administrative burden.
- ☐ Create an undue impact on operations.
- ☐ Fundamentally alter the nature or operations of the facility.
- ☐ Require lowering of current performance standard(s)

☐ An effective accommodation that would not pose an undue hardship was offered but rejected by the individual.