ADA REASONABLE ACCOMMODATION REQUEST FORM

(Submit to Supervisor, Department Head or Commissioner of Human Resources)

This form is to be used by Tompkins County employees. By completing this form, the County employee recognizes the need for, and is therefore requesting, an accommodation per the Americans with Disability Act of 1990 (as amended) and New York State Human Rights Law. Completion of this form, and all the content herein, is to remain confidential between the employee, Supervisor, Department Head, and/or Department of Human Resources.

Employee Name: Department:		Phone (home/work):		
		Position Title:		
Department Head:		Date of Request:		
1.	Do you currently have a limitation or conditi	on that is interfering with your ability to perform your job?		
2.	That job function or task(s) are you having difficulty performing?			
3.	Requested accommodations: Please describe in as much detail as possible the accommodation(s) you believe are needed to enable you to perform the essential functions of this job.			
4.	Please describe how the requested accommod	ations will assist you in performing the essential functions of your job?		
5.	Is your request time sensitive?	□ Yes □ No		
6.		de name, address, telephone and fax numbers. The physician may receive a impairment/disability and recommendations for accommodations.		
	Physician Name			

Physician Address:		
Physician Phone:		
Physician Fax:		
ADA confidentiality requirent about my condition, its fun examination to ascertain my	ments. I also understand that I may be requirenctional limitations, and appropriate accomm	s process will be maintained and used in compliance with red to provide my employer with medical documentation modations; and may be required to undergo a physical of my job. I hereby authorize the release of necessary a deemed necessary.
Employee Signature:		Date:
receipt of this form. Due to de	lelays that may be caused in communications	nodations will be made within ten (10) business days of the with physicians, no specific decision date can be provided will be made within ten (10) business days from the receipt
	For Human Resources	Use Only
Date Received:	Date	Reviewed:
Received by:	Re	viewed By: