STAFF REQUEST FOR REASONABLE ACCOMMODATION

DATE ____________________

NAME ____ PHONE ______________________

ADDRESS_________________________________ CITY _______________ ZIP _______________

POSITION __________________________________ SUPERVISOR ________________________

DESCRIPTION OF DISABILITY ____

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ACCOMMODATION REQUESTED

ACCESS TO FACILITY OR PROGRAM:

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JOB RESTRUCTURING/MODIFICATION:

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EQUIPMENT:

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OTHER:

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SIGNATURE of STAFF MEMBER

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SIGNATURE of ATTENDING PHYSICIAN