San Francisco Community College District

Formal Request for Reasonable Accommodation- Employee

(CONFIDENTIAL)

This form must be completed in order for a qualified disabled employee of the District to formally request reasonable accommodation. Your request will be processed as confidential in accordance with applicable law. As the employer, the District is ultimately responsible for determining what is a reasonable accommodation by reviewing all of the pertinent information and the needs of each employee on a case-by-case basis

Your request for reasonable accommodation will be reviewed and you will be notified by the District's decision in a reasonable time after this form is received by the ADA Coordinator.

The following to be completed by employee:

1. Your
Name:_____
__
(please print)

SSN#/ID#: _____

Status: ___Classified Staff ___Faculty ___Administrator

Address_____

City/State/Zip:_____

Telephone number: (home)_____
(work)_____

Current position:_____
Div/Dept.:_____

2. Reasonable Accommodation Request:

What type of accommodation do you need?

__ Modified work schedule __ Removal of communication barrier __ Job Restructuring
__ Change in procedure __ Purchase of assistive services __ Reassignment
__ Purchase assistive device __ Removal of architectural barrier __ Other:

Please describe the accommodation: (use extra sheets if needed)

_____

_____

_____

Please explain how you believe this accommodation will enable you to perform the essential functions of your position: (use extra sheets if needed)

_____

_____

_____

3. Essential Duties of Your Position:

Please identify the essential duties (do not include marginal duties) of your position for which you are requesting an accommodation:

1.
_____

2.
_____

3.
_____

4.
_____

4. Health Care Provider:

Please provide us with the name of your health care provider(s) who can assist with this request: (use extra sheet if needed)

Name: _____

Address:
_____

Phone: _____ Specialty:

_____

5. Major Life Activities:

Please check the major life activity(ies) you believe to be limited by your medical condition(s):

__ Walking __ Breathing __ Seeing __ Caring for Oneself __ Working __ Talking

__ Hearing __ Learning __ Performing Manual Tasks __ Other:

Please describe how the above activity(ies) is/are limited:

_____

_____

_____

6. Is your medical condition temporary? __ Yes __ No

If yes, please state the expected duration:

_____

7. Are you currently working? __ Yes __ No

If no, please specify the type of leave currently approved:

_____

If no, when do you expect to return to work?

_____

_____

(Attach additional sheets if necessary)

I hereby certify that I believe I am a qualified individual with a disability as defined by the law. I have received and reviewed the information brochure and require an accommodation to perform the essential functions of my position. I understand that a detailed review of my disability status may be required, and I agree to cooperate fully in this process. I further understand that if my request is granted, I am obligated to report any changes in my disability status which may require a re-evaluation of this request. Granting of this request does not signify approval of any future reasonable accommodation request for any other position within the District or if applicable, any department within the City and County of San Francisco.

Signature: _____ Date: _____
(Employee)

Return this completed form to:

Title 5/EEO/ADA Compliance Office
San Francisco Community College District
50 Phelan Ave., B619
San Francisco, CA 94112
Attn.: ADA Coordinator