



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?

- | | | |
|--|---|--|
| <input type="checkbox"/> Modified Work Schedule | <input type="checkbox"/> Removal of communication barrier | <input type="checkbox"/> Job Restructuring |
| <input type="checkbox"/> Change in procedure | <input type="checkbox"/> Purchase of assistive services | <input type="checkbox"/> Reassignment |
| <input type="checkbox"/> Purchase assistive device | <input type="checkbox"/> Removal of architectural barrier | <input type="checkbox"/> Other: |

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

BOARD OF TRUSTEES

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DR. DAVID MARTIN, CHANCELLOR

Please describe the accommodation (cont.) (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:

- I. _____
- 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:

**San Francisco Community College District
50 Frida Kahlo Way., Bungalow 702
San Francisco, CA 94112
Attn.: ADA Coordinator**