



## Reasonable Accommodation/Workplace Adjustment Request Form

Employee's Name:	Date:
Department:	Supervisor:

### REASONABLE ACCOMMODATION REQUEST

**Are you requesting a workplace adjustment and/or leave of absence because you are an older adult or have an underlying medical condition and are therefore at increased risk for severe illness as described by the CDC? [Centers for Disease Control: People at Increased Risk for Severe Illness](#).**

☐ Yes    ☐ No

**NATURE OF THE QUALIFYING CONDITION or DISABILITY:** (Please describe the nature, extent, and duration of your disability.)

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Are you requesting to work remotely? ☐ Yes    ☐ No

If "No", please describe your request for accommodation or leave of absence.

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**Are you requesting a workplace adjustment and/or leave of absence for any of the following circumstances which are unrelated to being at increased risk for severe illness?**

☐ Yes    ☐ No

- You are a caregiver for an individual who has a medical condition or disability;
- You need to care for a family member or dependent due to an illness related to Coronavirus (COVID-19);
- You need to care for your children impacted by school and daycare closures due to Coronavirus (COVID-19);
- You have been diagnosed or experiencing symptoms related to Coronavirus (COVID-19).

**NATURE OF THE QUALIFYING CONDITION OR DISABILITY:** (Please describe the nature, extent, and duration of your disability.)

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Are you requesting to work remotely? ☐ Yes    ☐ No

If "No", please describe your request for accommodation or leave of absence.

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I agree to fully cooperate with responding to my request, including providing medical documentation, if needed. I understand that I may not be provided with my specific request and that Human Resources in partnership with one's manager will review and consider all reasonable accommodations/workplace adjustments available.

I authorize the release of necessary confidential medical information regarding my disability to relevant managers as deemed necessary by Human Resources. Medical information received for requests due to an underlying medical condition is confidential. It will only be shared as needed with the appropriate individuals involved in responding to the request for reasonable accommodation.

Employee Signature \_\_\_\_\_ Date: \_\_\_\_\_

**For Human Resources Only**

Date Form Rec'd: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Accommodation/Workplace Adjustment Approved: ☐ Yes ☐ No

Description of Accommodation/Workplace Adjustment:

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