COUNTY OF SANTA CLARA
REQUEST FOR
ACCOMMODATION FORM B

TO BE COMPLETED BY EMPLOYEE'S MANAGER/SUPERVISOR OR DEPARTMENTAL/AGENCY DESIGNEE

Employee Name _____ Job Title _____

Name of Manager/Supervisor; _____ Phone # _____

Department/ Agency: _____

Describe the purpose of the employee's job:

List all essential functions of the employee position (refer to Procedures, Section m, B):

Meet with the employee. What job function(s) do(es) the employee need accommodation for? (The purpose of the interactive meeting with the employee is to discuss possible accommodation alternatives. The employee may have ideas as to what type of accommodation is needed.)

(INSERT DATE(S) OF INTERACTIVE MEETING(S))

Identify physical and/or mental limitations as related to the employee's ability to perform the essential job function(s):

Identify and list potential accommodations. (Please contact your Departmental EO Officer/Advisor or the Equal Opportunity Division):

Note: If you need additional space to respond to the questions, please attach additional sheet/s

ACCOMMODATION CAN BE PROVIDED

Select the most appropriate, effective, and reasonable accommodation(s). Describe the accommodation(s) you have chosen, duration, and the reasons, and include the timeline for implementing the accommodation(s):

DOCUMENT WHY ACCOMMODATION CANNOT BE PROVIDED - PLEASE REFER TO SECTION IV (C) (Contact your Departmental EO Officer/Advisor):

Manager/Supervisor Signature — Date

Departmental EO Officer/Advisor Signature (If applicable) — Date

Department/Agency Head Signature or Designee — Date

Copy: Manager/Supervisor
Departmental EO Officer/Advisor
Equal Opportunity Division
Department/Agency Head
Employee

Print & Sign

Note: If you need additional space to respond to the questions, please attach additional sheet/s