COUNTY OF SANTA CLARA
REQUEST FOR ACCOMMODATION

FORM A

TO BE COMPLETED BY EMPLOYEE

Name: ______________________________ Phone #: ______________________________

Job Title: ______________________________ Department/ Agency ______________________________

Describe why you need your job modified (you may include what your work restrictions are, however, DO NOT STATE YOUR MEDICAL CONDITIONS

Based on your understanding of your current position, what tasks and duties are you able to accomplish?

Based on your understanding of your current position, how could your job be modified and for how long do you need the accommodation(s)?

You must attach detailed medical documentation from your physician, or other health professional, or counselor, describing your capacities and restrictions. However, DO NOT STATE YOUR MEDICAL CONDITION.

Employee Signature ______________________________ Date: ______________________

EMPLOYEE: PROVIDE TO IMMEDIATE MANAGER/SUPERVISOR WITH DOCUMENTATION

MANAGER/SUPERVISOR: PROVIDE COPY TO COORDINATOR OF PROGRAMS FOR THE DISABLED, EQUAL OPPORTUNITY DIVISION, AND TO THE DEPARTMENT/AGENCY EQUAL OPPORTUNITY OFFICER/ADVISOR

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