Accommodations Request Form

Employee Name:_____

Building:_____

Room No.:_____

Accommodation Requested:_____

Medical condition requiring accommodation. (Please be as specific as possible and attach physician's note documenting the request.)

_____
_____
_____
_____
_____

Employee's Signature:_____ Date:_____

.....

District Use Only

Date Received: _____

Doctor's Note Included ☐

2nd Opinion of District Physician ☐

Accommodation Approved ☐

Accommodation Denied ☐

Comments:_____

_____

_____

_____ _____

Director of Human Resources **Date**

(1) Personnel File **(1) Accommodations File**