Supervisor's Review of Request for Reasonable Accommodation/Personal Assistance Services

Date of Review: ___________________ Date Received (HRO Only): _____________________

Name of Requesting Employee or Applicant: _______________________________________

Job Title (include PD#, PP-OCC-GRD, if known) : ____

Supervisor's Phone Number: _________________________________

Supervisor's Email Address: ___________________________________

Describe the disability and functional limitations (if known) :

Describe the requested accommodation and purpose for the request (if known) :

List essential functions of the position and indicate whether the employee can perform the function with the requested accommodation:

	Bending		Hearing		Reaching		Speaking		Other (Describe)
	Breathing		Interacting With Others		Reading		Standing		
	Caring For Self		Learning		Seeing		Thinking		
	Concentrating		Lifting		Sitting		Walking		
	Eating		Performing Manual Tasks		Sleeping		Working		

Essential Function — Can the employee perform the function with the requested accommodation?

1.____ ____ YES ____ NO ____ N/A*
2.____ ____ YES ____ NO ____ N/A*
3.____ ____ YES ____ NO ____ N/A*
4.____ ____ YES ____ NO ____ N/A*

*Accommodation not necessary to perform this function. Attach additional pages if necessary.

Was medical information provided? If yes, who provided the information and who reviewed the medical information?

Describe steps taken to evaluate the effectiveness and feasibility of the requested accommodation.

_______________________________ _____________
Signature (Supervisor) Date

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Print Name (Supervisor)