

# HABILITATION ASSISTANCE CORPORATION

## REQUEST FOR REASONABLE ACCOMMODATION

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Program: \_\_\_\_\_ Date: \_\_\_\_\_

To request a reasonable accommodation from Habilitation Assistance Corporation (the agency) applicant or employee should complete this form and submit it to the Human Resource Director. This information will be kept separate from the Applicant's employment file or the Employee's personnel file.

The purpose of this form is to assist the agency in determining whether, or to what extent, a reasonable accommodation is required for an applicant/employee to perform the essential functions of his or her job safely and effectively. If additional space is needed for request, please attaché a separate sheet of paper.

### TO BE COMPLETED BY THE APPLICANT/EMPLOYEE

1. Identify and describe the physical or mental disability, illness, condition or disease which is the basis for your request for reasonable accommodation(s) by the agency. (See definition of "disability" on bottom of form).
2. Identify and describe the essential function(s) of the position (listed above) which you are unable to perform without reasonable accommodation(s) by the agency. (See definition of "Reasonable Accommodation" on bottom of form).
3. Identify and describe the reasonable accommodation(s) you believe is (are) needed to enable you to perform the essential functions of the position properly and safely, including special equipment, changes in the physical layout of the job or other accommodation.

4. Identify and describe any special methods, skills, or procedures which would enable you to perform the essential functions of the position:

5. Identify and describe any equipment, aids or services that you are willing to provide and utilize:

I certify that I have read and reviewed the job description for the position and/or have been informed of the essential functions of the job. I further certify that the foregoing statements are complete, accurate and true to the best of my knowledge and I understand that misstatement or omission of fact may be cause for dismissal. I also understand the agency may require me to undergo testing or evaluation by medical personnel for the purpose of establishing the existence and extent of my disability, illness, condition or disease and my ability to perform job-related functions with or without reasonable accommodation. I further understand that the agency is not obligated to provide any specific accommodation(s) I request, but will evaluate my request in light of all information available in making a determination of what is a reasonable accommodation.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***“Disability” includes a physical or mental impairment that substantially limits one or more major life activities. Major life activities include such things as caring for oneself, performing manual tasks, walking, sitting, standing, lifting, reaching, seeing, hearing, breathing, learning, and working.***

***“Reasonable Accommodation” includes any modification of the job or work environment to enable an employee to perform the essential functions of the job in question.***

***These definitions are provided only as a guide for completing this form. Nothing in this form is intended to alter the legal definitions of these terms or impose obligations on the agency not required by law.***

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