**Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | | |
| Employee ID: | [Employee ID] | Department: | [Department Name] |
| Position: | [Employee’s Position] | Supervisor: | [Supervisor Name] |
| Contact Number(s): |  | Email Address: | [Email Address] |

**Accommodation Request Details**

|  |  |  |
| --- | --- | --- |
| Date of Request: | (DD/MM/YYYY) | |
| **Nature of Accommodation Requested:** | Physical Accessibility | Modified Work Schedule |
| Modified Duties | Assistive Devices/Equipment |
| Other (Please specify): | |

**Reason for Request**

|  |  |
| --- | --- |
| Describe the medical condition or disability necessitating the accommodation: |  |
| Describe how the accommodation will assist you in performing your job duties: |  |

**Medical Information**

|  |  |  |
| --- | --- | --- |
| **Is a medical provider's note attached?** | Yes | No |
| If yes, provide details from the medical provider’s note (without disclosing sensitive health information): | | |

**Accommodation Details**

|  |  |
| --- | --- |
| Specific accommodation(s) requested: |  |
| Duration of the accommodation (if temporary): |  |
| Have you requested this accommodation before? | Yes No **If yes, provide details:** |

**Employee Acknowledgement**

|  |  |  |
| --- | --- | --- |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Employee Name), certify that the information provided in this form is accurate and complete. I understand that my employer may need to discuss my request with my supervisor, Human Resources, or my medical provider (with my permission) to assess and implement the accommodation. | **Employee Signature:** | **Date:** (DD/MM/YYYY) |

**Supervisor/Manager Review**

|  |  |  |  |
| --- | --- | --- | --- |
| **Comments:** |  | | |
| **Supervisor/Manager Name:** |  | | |
| **Signature:** |  | **Date:** | (DD/MM/YYYY) |

**Human Resources Review**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Request Received:** | | **Date:** | (DD/MM/YYYY) |
| **Action Taken:** |  | | |
| **Accommodation Approved:** | Yes No Partially (explain): | | |
| **HR Representative Name:** |  | | |
| **Signature:** |  | **Date:** | (DD/MM/YYYY) |

**For Office Use Only**

|  |  |  |  |
| --- | --- | --- | --- |
| **Implementation Date:** | (DD/MM/YYYY) | **Follow-Up Date:** | (DD/MM/YYYY) |
| **Processed By:** |  | | |
| **Additional Notes:** |  | | |

This form ensures a structured process for employees to request reasonable accommodations and for employers to document and assess those requests.