DEPARTMENT OF HEALTH AND HUMAN SERVICES

CONFIRMATION OF REQUEST FOR REASONABLE ACCOMMODATION

NAME *(Employee or Applicant)*		TODAY'S DATE
NAME OF SUPERVISOR *(If Employee)*	TELEPHONE NO.	DATE OF REQUEST

NAME OF 3RD PARTY REQUESTOR

☐ Health Care Provider ☐ Family Member ☐ Representative

EMPLOYEE'S CENTER / OFFICE / DIVISION

EMPLOYEE'S JOB TITLE	EMPLOYEE'S SERIES	EMPLOYEE'S GRADE

TELEPHONE NO. OF APPLICANT, EMPLOYEE OR 3RD PARTY REQUESTOR

ACCOMMODATION REQUESTED *(Be specific, e.g., adaptive equipment, flexi-place/time, interpreter)*

REASON FOR REQUEST

EXPLANATION OF ANY TIME SENSITIVE ISSUES RELATING TO THE REQUEST

FOR EEO USE ONLY

R.A. Specialist

Decision Maker

Tracking #

RETURN FORM TO REASONABLE ACCOMMODATION SPECIALIST