



RIVERSIDE COUNTY DISABILITY ACCESS OFFICE
WORK ACCOMMODATION REQUEST AND DOCUMENTATION OF DISABILITY

Employee Section:

Name of Employee: Employee #: Position:

Supervisor: Department:

Accommodation Request:

[Blank lines for accommodation request details]

Describe as completely as possible the type of accommodation you are seeking. If appropriate, please list specifications for products indicated. If the request above is for intermittent time off, please have your medical provider complete section 3 below.

I request I be provided with the above indicated work accommodations in compliance with the Americans with Disabilities Act (ADA)/Fair Employment and Housing Act (FEHA). I understand under ADA/FEHA, only reasonable accommodations are required.

Employee Signature: Date:

Healthcare Provider Section:

1. I (Provider), confirm that (Patient) is under my care. Based on my medical assessment, I verify that my patient has a disability as defined by law, and the resulting functional limitations are outlined below:

Functional Limitations (Work Restrictions): [Blank lines for provider input]

The anticipated length of time for the above documented limitations to continue is (check one):

Temporary - until: Permanent/ongoing Through next appointment:

2. Intermittent Leave (if applicable):

Time off will be: Scheduled (appointments/treatment) Unforeseen (flare-ups/unpredictable)

Frequency: Times per Week(s) months(s)

Duration: Hours Days(s) per event

Provider's Name: Phone: Fax:

Address: City: Zip Code:

Provider Signature: Date: