RIVERSIDE COUNTY DISABILITY ACCESS OFFICE

WORK ACCOMMODATION REQUEST AND DOCUMENTATION OF DISABILITY

Employee Section:

Name of Employee: _____ Employee #: _____ Position:_____

Supervisor: _____ Department: _____

Accommodation Request: _____

_____

_____

_____

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 2 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:

His/her health condition **affects** the following major life activity/activities ***(REQUIRED)***:

☐ Bending	☐ Interacting with others	☐ Hearing	☐ Seeing	☐ Walking
☐ Breathing	☐ Learning	☐ Speaking	☐ Sitting	☐ Working
☐ Caring for self	☐ Lifting	☐ Standing	☐ Concentrating	☐ Other: _____

Functional Limitations (Work Restrictions): _____

_____

_____

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: _____