CS-388A

REASONABLE ACCOMMODATION REQUEST FORM
(Please forward initially to the ADA Coordinator of your Agency)

Name: _____ **Day Phone # (VOICE)** _____ _____
(Print Last Name, First Name, MI) Soc. Sec. #

Current Title in State Government (if applicable): _____

Classification Title (Offered): _____

I am an applicant/employee for the position named above and may require a "reasonable accommodation" to perform the essential function(s) of the job. I hereby request that the ADA Coordinator and/or other individuals identified in the Reasonable Accommodation Policy of the State of Rhode Island contact me regarding this need for reasonable accommodations and authorize them to verify this request.

I understand that I have a right to appeal the decision of the ADA Coordinator noted below. Upon appeal, a job analysis, by the Office of Rehabilitative Services or its designated vendor, will be completed and a recommendation made within 60 calendar days of the receipt of such request.

PLEASE DESCRIBE BELOW THE ACCOMMODATION YOU MAY NEED: _____

_____

_____

I AUTHORIZE _____ **TO RELEASE MEDICAL DOCUMENTATION TO VERIFY MY NEED FOR A REASONABLE ACCOMMODATION DUE TO MY DISABILITY.**
(Health Professional's Name)

Health Professional's Name: _____ **Phone #:** _____
Address: _____
_____

_____ _____
Applicant/Employee Signature Date

_____ **DO NOT WRITE BELOW THIS LINE** _____

1. Agency ADA Coord./Appt. Auth Response: ____Approved ____Not Needed ____Denied

_____
_____

_____ _____ _____
Authorized Name (Print) Authorized Signature Date

2. Office of Rehabilitative Services Response: ____Approved ____Not Needed ____Denied

_____
_____

_____ _____ _____
Authorized Name (Print) Authorized Signature Date

3. ADA Equipment Committee Response: ____Approved ____Not Needed ____Denied

_____
_____

_____ _____ _____
Authorized Name (Print) Authorized Signature Date

4. If Workers' Compensation Disability:
Workers' Compensation Response: ____Approved ____Not Needed ____Denied

_____
_____

_____ _____ _____
Authorized Name (Print) Authorized Signature Date

PLEASE COMPLETE REVERSE SIDE ONCE ACCOMMODATION HAS BEEN APPROVED

Description of Approved Reasonable Accommodation

APPROVED BY:
Appointing Authority

Name (Please Print)	**Agency (Please Print)**
Signature	**Date**

ACCEPTED BY:
Employee/Applicant

Name (Please Print)	
Signature	**Date**
Union Official Signature/Title (if necessary)	**Date**

Forward a copy of the approved Reasonable accommodation Form to:
State ADA Coordinator
Governor's Commission on the Handicapped
555 Valley Street, Bldg. 51
Providence, RI 02908-5686

EACH SIGNATORY MUST RECEIVE A SIGNED ORIGINAL
Agency ADA Coordinator shall retain the signed original in a confidential file