Orange County Government

ADA Request for Reasonable Accommodations Form

Name (Print): _____ Employee ID: _____

Department: _____ Division: _____

Phone: _____ Email: _____

Condition(s) which I believe affects my ability to perform the essential functions of my job:

Accommodations(s) I am requesting:

I request that the accommodation(s) be: ◯ Permanent ◯ Temporary until _____

I have attached any supporting documentation that may be helpful in evaluating this request for accommodation.: ◯ Yes ◯ No

By signing this request form, I certify that the information provided is true and correct. If information concerning my request changes I will contact the HR representative for my Division.

I hereby authorize Orange County to contact my healthcare provider to verify the reason for my request or for any additional information concerning my request for accommodation. Any information obtained will be kept pursuant to the HIPAA Privacy rule.

Employee's Signature: _____ Date: _____

For Human Resources Use only

HR Representative's Signature : _____ Date: _____

Health Care Provider Documentation received : ◯ Yes ◯ No Date: _____