

**COUNTY OF YOLO
DISABILITY REASONABLE ACCOMMODATION
EMPLOYEE REQUEST FORM**

Any County employee with a disability may request an accommodation at any time. This form should be completed by the requesting employee and returned to his/her supervisor or manager for consideration of the request. Provide additional sheets if needed.

Name _____ Date _____

Department _____ Position _____

1. My specific functional (physical/mental) limitation is:

2. State the specific job duties for which you are requesting accommodation:

3. State the accommodation you are requesting. Please be as specific as possible (i.e. specific duties that may be changed; modifications to work schedule or job site; purchase items needed; release time for treatment, etc....):

4. If possible, list your suggestions how your limitation(s) can be accommodated:

ACKNOWLEDGEMENT

I certify that I have a physical or mental condition that requires reasonable accommodation which I believe will assist me to perform the essential functions of my job. I understand that I may be requested to submit an Authorization for the Release of Medical Information form that authorizes my physician or other health care professional to provide Yolo County with medical information needed to evaluate this request for reasonable accommodation. I understand that this document and medical verification will be kept confidential and only used to evaluate this request.

Signature _____ Date _____