Tompkins County Department of Human Resources
125 East Court Street, Ithaca, NY 14850 | P: (607) 274-5526 | F: (607) 274-5401 | www.TompkinsCountyNY.gov
*Inclusion through Diversity*

# ADA REASONABLE ACCOMMODATION REQUEST FORM

**(Submit to Supervisor, Department Head or Commissioner of Human Resources)**

This form is to be used by Tompkins County employees. By completing this form, the County employee recognizes the need for, and is therefore requesting, an accommodation per the Americans with Disability Act of 1990 (as amended) and New York State Human Rights Law. Completion of this form, and all the content herein, is to remain confidential between the employee, Supervisor, Department Head, and/or Department of Human Resources.

Employee Name: _____ Phone (home/work): _____

Department: _____ Position Title: _____

Department Head: _____ Date of Request: _____

1. **Do you currently have a limitation or condition that is interfering with your ability to perform your job?**

_____

_____

2. **What job function or task(s) are you having difficulty performing?**

_____

_____

3. **Requested accommodations:** Please describe in as much detail as possible the accommodation(s) you believe are needed to enable you to perform the essential functions of this job.

_____

_____

4. **Please describe how the requested accommodations will assist you in performing the essential functions of your job?**

_____

_____

5. **Is your request time sensitive?** ◯ **Yes** ◯ **No**

6. **Physician contact information:** Please provide name, address, telephone and fax numbers. The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations.

Physician Name: _____

Physician Address: _____

Physician Phone: _____

Physician Fax: _____

I understand that all the information obtained by my employer during this process will be maintained and used in compliance with ADA confidentiality requirements. I also understand that I may be required to provide my employer with medical documentation about my condition, its functional limitations, and appropriate accommodations; and may be required to undergo a physical examination to ascertain my ability to perform the essential functions of my job. I hereby authorize the release of necessary confidential medical information to the Department of Human Resources as deemed necessary.

Employee Signature: _____ Date: _____

*[To signatory: In non-physician review cases, decisions regarding accommodations will be made within ten (10) business days of the receipt of this form. Due to delays that may be caused in communications with physicians, no specific decision date can be provided for physician review cases, only that decisions regarding accommodations will be made within ten (10) business days from the receipt of medical documentation.]*

For Human Resources Use Only

Date Received: _____ Date Reviewed: _____

Received by: _____ Reviewed By: _____