OCCUPATIONAL MEDICAL SERVICES (OMS)

EMPLOYEE REASONABLE ACCOMMODATION REQUEST FORM

This form is to be completed by employees when requesting an accommodation or modification to a prior accommodation under the American's with Disabilities Act (ADA). Your Health Care Provider will be required to complete the ADA Medical Questionnaire which will be used to assist the County Employee Medical Examiner in evaluating your medical condition.

(Please print clearly or type in)

PART I: EMPLOYEE REQUEST

(To be completed by employee and forwarded to Disability Program Manager)

NAME: _____ TELEPHONE: _____

DEPARTMENT: _____ POSITION: _____

SUPERVISOR: _____ SUPERVISOR TELEPHONE: _____

ACCOMMODATION REQUESTED:

NOTE: The ADA does not require that a specific or requested accommodation be granted but rather that an appropriate reasonable accommodation be made to a qualified individual with a disability. The County will make all efforts to reasonably accommodate the employee in his/her current position before exploring alternative placement.

PART II: TO BE COMPETED BY OMS:

Date request received:___/___/___
Date of Intake Interview Conducted by Disability Program Manager (DPM):
Date medical information received: _____
If you are a MCGEO collective bargaining unit employee, do you want the union to receive a copy of this request? _____

PART III: TO BE COMPLETED BY SUPERVISOR

Department is able to provide accommodation: ☐ Yes ☐ No
If No, Please provide information as to why accommodation can not be granted.

Suggested Alternative Accommodation:

Supervisor Signature:_____ Date:_____
Department is responsible for accommodations under $500.00. OHR will share expenses on accommodations greater than $500.00.