Request for Workplace Accommodation

**Based on Employee’s Own Health Condition**

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| **Section 1: Employee Information and Documentation**  **INSTRUCTIONS to the EMPLOYEE:**  If you would like to request a workplace accommodation based on your own disability through the Department of Human Resources, please complete this form. You may also request an accommodation by speaking directly with your supervisor. The Department of Human Resources and your supervisor cannot require that you complete this form. This form is provided to assist employees in requesting accommodations through the Department of Human Resources. To request a workplace accommodation through the use of this form[, answer all questions fully and completely and be sure](https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html) to sign the form on the last page, along with documentation from your physician which supports your request. You may provide **either** a letter from your medical provider or have your medical provider complete the certification included on this form. To ensure that your request is received and timely evaluated, employees must submit this form and the requested healthcare provider documentation to: [FamilyLeave@dallascityhall.com.](mailto:FamilyLeave@dallascityhall.com) Be advised that your employer is not required to provide your requested accommodation. However, all requests will be evaluated after receipt of the healthcare provider documentation. If your requested accommodation is not granted, you may be offered a different accommodation or requested to provide additional medical documentation, as appropriate. We recommend providing several accommodation options, if possible. | | |
| First | Middle | Last |
| **Employment Information** | | |
| Date of Hire | Job Title | Employee ID# |
| Department Supervisor Supervisor’s Telephone Number | | |

**Requested accommodation**:

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| --- | --- |
| Employee Signature | Date |

**Section 2: Medical Provider Documentation** - **For Completion by the HEALTHCARE PROVIDER INSTRUCTIONS to the HEALTH CARE PROVIDER**:

Please verify below the information that documents your patient’s need for an accommodation due a disability. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Attach additional pages if necessary. Please be sure to sign the form on the last page. To ensure that your patient’s request is received and addressed, please submit this form to: [FamilyLeave@dallascityhall.com.](mailto:FamilyLeave@dallascityhall.com)

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| **Healthcare Provider Information** |  |
| Healthcare Provider’s Name | Healthcare Provider’s Business Address |
| Type of Practice/Medical Specialty | Phone Number |
| e-mail | Fax Number |
| **Medical Certification** |  |
| Patient’s Condition and reason for accommodation |  |

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Medically recommended accommodation options.

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| Signature of Healthcare Provider | Date |