

**MARICOPA COUNTY
ADA ACCOMMODATION REQUEST FORM**

A. POLICY STATEMENT ON REASONABLE ACCOMMODATIONS

The Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101 et seq., prohibits discrimination in employment against qualified individuals with disabilities. Maricopa County is committed to ensuring it does not discriminate against qualified individuals with disabilities. The County will provide reasonable accommodations to qualified individuals with disabilities unless there is an undue hardship to the County. All requests for reasonable accommodations will be kept separate from the employee's personnel file and will be kept confidential except the information will be provided to those supervisors/managers on a need to know basis. If an employee needs assistance in filling out this request for an accommodation, the employee should contact the Maricopa County Health Initiatives Department, Disability Management Unit (506-1010), then press 5, then 2.

B. TO BE COMPLETED BY EMPLOYEE:

Name of Employee: _____ Present Position: _____
Department: _____ Supervisor's Name: _____ Phone Number: _____
Work Phone: _____ Home or Cell Phone: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

1. I am requesting the following reasonable accommodation(s) so that I can perform the essential functions of my present position:

2. I am making this request for an accommodation because I am an individual with a physical or mental impairment which substantially limits one or more major life activities. I have the following physical or mental impairment:

3. I have the following functional limitations as a result of this impairment:

Maricopa County may request medical documentation to verify the type, extent, and duration of my limitations by my Health Care Provider. I agree to provide such verification in the time requested if the Maricopa County Human Resources Department requests verification, in writing, after reviewing this request. I also agree to provide the essential functions of my position to my Health Care Provider.

(Date)

(Signature of Applicant/Employee)

Please return completed form to:
Maricopa County Employee Health Initiatives Department
Disability Management
301 W. Jefferson, Suite 160
Phoenix, AZ 85003

VERIFICATION OF REQUEST FOR
ADA REASONABLE ACCOMMODATION
BY HEALTH CARE PROVIDER

Instructions: The Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 et seq., prohibits discrimination in employment against qualified individuals with disabilities. Maricopa County is committed to ensuring that it does not discriminate against qualified individuals with disabilities. The County will provide reasonable accommodations to qualified individuals with disabilities unless the accommodation would impose an undue hardship on the County.

On _____ (date), _____ (name of Employee)
requested a reasonable accommodation under the ADA. The request for a reasonable accommodation is
attached. Please review the request and answer the questions below.

To be filled out by Employee's Health Care Provider:

1. Have you reviewed the attached Request for a Reasonable Accommodation?

Yes _____ No _____

2. Does your patient have a physical or mental impairment?

Yes _____ No _____

If yes, please describe the specific impairment below, using a DSM-IV description and code if the individual has a mental impairment.

3. A. What are the individual's limitations?

- B. What is the duration of the limitation(s)? Until _____ date or ___ Indefinite or ___ Permanent.

- C. What specific essential functions (refer to essential functions provided by individuals) are affected by these limitations?

_____(Signature of Medical Professional)

_____(Printed Name)

_____(Address)

_____(City) (State) (Zip)

_____(Phone Number)

_____(Date)

Return this information to the patient or to:
Employee Health Initiatives Department
Disability Management Unit
301 W. Jefferson, Suite 160
Phoenix, AZ 85003 Fax: (602)506-8974