County of Santa Clara
Form A
Employee Request for Reasonable Accommodation
(To be completed by Employee)

The County of Santa Clara encourages use of this form by individuals requesting a reasonable accommodation of a disability or medical condition. If you have not completed the form, your supervisor or manager will ask you to complete it to assist the County in evaluating your request.

NOTE: Current medical documentation from a licensed health care provider, other health professional, or counselor that details your physical/mental limitations, capacities or restrictions, may be required and should be submitted. If it is required and not submitted, your request may not be eligible to move forward in the assessment process and a final determination cannot be made.

Employee Name:	Classification/Job Title:	Employee ID #:
Work Location Address: Work Schedule:	Work Telephone: Personal Telephone:	POD # (SSA Only)

Supervisor/Manager Name:	Department/Agency	Telephone:

SECTION I:

A. What are your current limitations, (i.e. sleeping, walking, reading, working etc.) **or work restrictions** (i.e., unable lift more than # lbs.; unable to type for more than #minutes per hour; or unable to work during episodic flare ups, etc.) **caused by your disability or medical condition/restrictions?** ***You are not requested or required to disclose any diagnosis, disability or medical condition.***

B. What are the specific job task(s) or duty (ies) that are more difficult as a result of the limitations/work restrictions you noted above? *(Examples: all typing and computer work; all of my duties and responsibilities are affected by my limitations; unloading daily shipments, sleeping, walking, reading etc.)*

C. What accommodation(s) are you requesting, (if known) *and* how will the accommodation help you with performing the job tasks or duties listed above. Be as specific as possible. *(Examples: request alternative work schedule to allow a full day of work; request voice activated software which will limit my typing, allowing me to continue to complete computer duties, etc.)* If this request is specific to accessibility, please contact the Equal Opportunity Department. NOTE: The Department may provide an alternative accommodation which they deem most effective.)

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D. Are the limitation(s) listed above: ☐ Permanent -or- ☐ Temporary- If temporary, what is the anticipated duration: _____. If you have both permanent and temporary limitations, list and specify each separately).

E. If you are requesting a leave, do you intend to return to work with the County of Santa Clara at the conclusion of your leave? ☐ No ☐ Yes

F. Is this request related to a Workers' Compensation (WC) claim? ☐ No ☐ Yes - If yes, provide:

Date of Injury: _____ WC Claim #:_____ Adjuster Name: _____

SECTION II:

Within 10 working days of making a request for accommodation, you will have an interactive discussion with a supervisor or manager regarding this request. The Department will provide you a final determination within 20 working days following the conclusion of the 'interactive' process.

Can you continue working without an accommodation until a final determination is made? ☐ Yes ☐ No
(If not, the department may provide you a temporary accommodation, which may include an approved leave pending a final determination)

If you are unable to wait for a determination *because* the duration of your request will end within 20 working days, contact your department Reasonable Accommodation Coordinator or the County Equal Opportunity Department at (408) 993-4840 or EOD@eod.sccgov.org

SECTION III:

I understand I am not required to disclose my diagnosis, disability or medical condition; but I certify that I have a disability or medical condition that requires a reasonable accommodation, as requested above.

I have provided medical documentation (attached) to support my request from:

Doctor Name: _____

Date of doctor's note: _____

Employee Signature:	**Date of completion of this Form:**	**Date of Reasonable Accommodation Request:**
_____	_____	_____