CONFIDENTIAL

REQUEST FOR ASSESSMENT/ REASONABLE ACCOMODATION FORM

To whom it may concern:

[Employee] has notified the City of **_________**, his/her employer of a change in his health status which may affect the ability to perform the essential functions of his/her assigned position. In order to determine if the employee is able to perform the duties described in the attached job description with or without an accommodation.

[insert title of position and attach applicable job description.]

A copy of the Eemployee's job description is attached to assist you in providing this information. However, if you require additional information to complete this assessment, please contact me:

[Insert contact information of hiring manager or HR director.]

The Employee has been advised this form must be completed by you and returned no later than **[insert reasonable return date], 2021**. Failure to return the form by that date may jeopardize the employee's continued employment. The completed form should be returned to my attention at the contact information above.

1. Is the Employee substantially limited in any major life activities as the result of her health condition? If so, please identify which major life activities are limited:

2. Is Employee unable to perform any of the essential functions of the job as described in the attached job description? If so, please identify each limitation or inability to perform and the expected duration of the limitation. If yes, please also complete the attached return to work form for additional detail and explanation.

3. Does the condition cause Employee any functional limitation in the ability to reach, stand, bend, grip, concentrate, speak, etc.? If so describe the limitations and the expected duration.

4. Based upon your knowledge of the Employee's condition, are there any accommodations that the City can provide that you believe would permit the Employee to perform the essential function of the job?

A. If you determine leave or a reduced schedule is an accommodation which would enable this Employee to perform the essential functions of the position, please indicate what leave is required and an estimated duration of this need?

B. If the condition causes episodic flare-ups, periodically preventing the Employee from performing assigned job functions, please advise as to the anticipated frequency and duration of the episodes, as well as any accommodations the Employee will require as a result of the episodes.

Date of most recent treatment: ____________________

Probable Duration of Condition: ____________________

______________________ ___________________________________

Date Physician’s signature