

**REASONABLE ACCOMMODATION REQUEST FORM**

(Please forward initially to the ADA Coordinator of your Agency)

Name: \_\_\_\_\_ Day Phone # (VOICE) \_\_\_\_\_  
Please print-Last Name, First Name, MI (TDD/TT) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Current Title in State Government (if applicable): \_\_\_\_\_

Classification Title (Offered): \_\_\_\_\_

I am an applicant/employee for the position named above and may require a "reasonable accommodation" to perform the essential function(s) of the job. I hereby request that the ADA Coordinator and/or other individuals identified in the Reasonable Accommodation Policy of the State of Rhode Island contact me regarding this need for reasonable accommodations and authorize them to verify this request. I do hereby waive my rights of confidentiality of information (medical/personnel or otherwise) so that pertinent information will be forwarded to other departments for processing. I understand that I have a right to appeal the decision of the ADA Coordinator noted below. Upon appeal, a job analysis by the Office of Rehabilitative Services or its designated vendor, will be completed and a recommendation made within 60 calendar days of the receipt of such request.

PLEASE DESCRIBE BELOW THE ACCOMMODATION YOU MAY NEED:

I AUTHORIZE \_\_\_\_\_ TO RELEASE MY MEDICAL RECORDS TO VERIFY MY NEED FOR  
(Health Professional's Name) A REASONABLE ACCOMMODATION DUE TO MY DISABILITY.

Health Professional's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Applicant/Employee Signature Date

\_\_\_\_\_  
Union Official's Signature/Title (if necessary) Date

**DO NOT WRITE BELOW THIS LINE**

1. Agency ADA Coord./Appt. Auth. Response: \_\_\_\_\_ Approved \_\_\_\_\_ Not Needed \_\_\_\_\_ Denied

\_\_\_\_\_  
Authorized Name (Print) Authorized Signature Date

2. Office of Rehabilitative Services Response: \_\_\_\_\_ Approved \_\_\_\_\_ Not Needed \_\_\_\_\_ Denied

\_\_\_\_\_  
Authorized Name (Print) Authorized Signature Date

3. ADA Equipment Committee Response: \_\_\_\_\_ Approved \_\_\_\_\_ Not Needed \_\_\_\_\_ Denied

\_\_\_\_\_  
Authorized Name (Print) Authorized Signature Date

4. If Workers' Compensation Disability:  
Workers' Compensation Response: \_\_\_\_\_ Approved \_\_\_\_\_ Not Needed \_\_\_\_\_ Denied

\_\_\_\_\_  
Authorized Name (Print) Authorized Signature Date

Description of Approved Reasonable Accommodation

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**APPROVED BY:**  
Appointing Authority

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Name (Please Print)

Agency (Please Print)

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Signature

Date

**ACCEPTED BY:**  
Employee/Applicant

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Name (Please Print)

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Signature

Date

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Union Official Signature/Title (if necessary)

Date

**Forward a copy of the Approved Reasonable Accommodation Form to:**  
State ADA Coordinator  
Governor's Commission on the Handicapped  
555 Valley Street, Bldg. 51  
Providence, RI 02908-5686

**EACH SIGNATORY MUST RECEIVE A SIGNED ORIGINAL**

Agency ADA Coordinator shall retain the signed original in a confidential file