



**Leon County
Employee/Applicant Request for Reasonable
Accommodation Form**

Initial requests for reasonable accommodations shall be submitted to the supervisor and the Employee Relations Manager in the Human Resources Division. All medical information is maintained separately from all personnel records and shall be kept confidential.

PART I – REQUESTOR’S INFORMATION.

Section 1 – Employee/Applicant Information (To be completed by requestor and returned to supervisor or Board’s designated responsible person for reasonable accommodations):

Date: _____ **Check one:** **Employee** **Applicant**
Name: _____ **Department/Division:** _____
Job Title: _____ **Work Site Location:** _____

Work Telephone #: _____ **Home Telephone #:** _____

Supervisor’s Name: _____

Section 2 – Accommodation Request:

I am requesting accommodation(s) for the following reason(s) – check relevant box(es):

- To complete the employment application process.
- To perform essential job function(s).
- To have equivalent benefits and privileges of non-disabled employees.
- To obtain evacuation assistance in a time of emergency.
- Other (provide explanation): _____

How does your disability restrict your ability to accomplish the essential functions of your job responsibilities?

What type of accommodation(s) do you believe would be effective?

The review process includes an evaluation of all relevant information. This may include an interview with you and/or your supervisor. After completion of the review, you will receive a final copy of this form from Human Resources regarding the County’s decision. If you have any questions, please the Employee Relations Coordinator at 850-606-2400.

PART II – APPROVAL(S).

Section 1 – Human Resource Approval

I have received your request for an accommodation. Approved Need more Review

Comments: _____

Employee Relations Coordinator: _____ Date: _____

Section 2 – Notification of need for additional information (To be completed by the Employee Relations Manager):

We are continuing to assess your request. To make a determination, we need the following information:

Medical documentation. Please inform your doctor of your application for an accommodation and have your doctor send us medical documentation, indicating the limitations placed on your life functions and activities. Information should be returned by the following date _____ to your supervisor or the Employee Relations Coordinator, Human Resources Division, 315 South Calhoun Street, Suite 210, Tallahassee, Florida 32301.

Other:

We require no additional information from you.

Section 3 – Accommodation(s) Granted

Description of Accommodation:

Requestor’s Acknowledgment: _____ Date: _____

Requestor’s Comments: _____

Employee Relations Coordinator: _____ Date: _____