REASONABLE ACCOMMODATION REQUEST FORM

Submit completed form to the Office of Civil Rights at:
1220 N Steet, Sacramento, CA 95814 or
Civil_Rights@cdfa.ca.gov

Part I: Requestor Information

Employees are to complete all sections. Job or exam applicants are only required to complete sections relevant to them.

Name:		Home/Cell Telephone:
Home Address:	Office Location/Address:	Division/Branch/DAA:
Preferred Email Address:	Supervisor:	Supervisor Telephone:

Part II: Accommodation Request Information

Please complete all of the following sections. The request will be considered incomplete if all information is not provided. A determination cannot be made on an incomplete request. Attach additional sheets of paper if necessary.

This request requires a: ☐ Permanent Accommodation ☐ Temporary Accommodation	If temporary, what is the expected duration?
Describe in your own words how your disability or medical condition limits your ability to perform the essential functions of your job or otherwise receive treatment equal to that provided to other employees. If a current employee, please **ATTACH YOUR DUTY STATEMENT**	
What is the accommodation or modification you are requesting? Provide the name of vendor(s), approximate costs, and availability of goods and services requested if known.	
Explain how the requested accommodation will assist you in performing the essential functions of your job.	

List any alternative accommodations that would also allow you to complete the essential functions of your job.

Part III: Verification and Attestation of Accuracy

Attestation of Accuracy: With my signature below, I certify that the above information is complete and accurate to the best of my knowledge and that I certify I have a disability or medical condition that requires reasonable accommodation. I understand that my request for a reasonable accommodation may not be granted if it is unreasonable, creates an undue hardship, or is a direct threat to myself or others. I also understand that failure to provide adequate notice of my need and/or failure to engage in the interactive process may delay my request. I acknowledge that the Department requires medical documentation certifying my limitations as they relate to my duties if my medical condition or disability is not obvious. I acknowledge that if the documentation provided is not sufficient, the Department may request additional clarifying information. I further acknowledge that any intentional misrepresentation contained in this request may result in disciplinary action.

Privacy Statement: This document contains personal information. Pursuant to the Information Practices Act and Civil Code 1798.21, it shall be kept confidential in order to protect against unauthorized disclosure. Information may be shared as minimally necessary in order to assess accommodation requests and implement any approved accommodation.

Requestor Signature	**Date:**

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Part IV: Medical Verification from Attending Health Professional

This request must include the attending health professional's verification (medical note) that meets the following criteria. If the attending health professional's verification is not attached or does not meet the following criteria, the Department must obtain the information from the attending health professional before the request is considered complete and a determination can be made.

1. Documentation must provide evidence of a disability or medical condition that includes a medical recommendation for reasonable accommodation
2. Documentation must be on the official letterhead of the qualified health professional's organization and contain the name of the treating health professional and their contact information. Note: Acceptable treating physicians are doctors of medicine (M.D.), Chiropractic (D.C.), Osteopathic (D.O.), Podiatry (D.P.M.), Psychology (Psy.D. or Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), or Nurse Practitioner (N.P.)
3. The document must be dated and signed by the health professional.
4. The limitations caused by the disability or condition must be described in detail as they currently exist only in relation to the job, and if the request is permanent or temporary. If temporary, the date the accommodation is expected to end must be specified.
5. Documentation must explain how the accommodation will permit the employee to perform their essential functions.
6. If it is recommended that an item be purchased, indicate the specific model or product if possible. If it is recommended that the work site be modified, or specific duties be restructured or shared, describe the necessary action.

If information received is insufficient for making a determination, additional information may be required from the attending health professional.

Part V: Authorization for the Release of Medical Information

☐ I authorize you to release to the CDFA Office of Civil Rights, 1220 N Street, Sacramento, CA 95814, information concerning my physical or mental health in order to assist in a determination of my reasonable accommodation request.

Health Professional Name:	Health Professional Organization:
Organization Address:	Health Professional Telephone:
Authorization shall be valid for a period of 90-days after the date of my signature or earlier if revoked by me in writing to the CDFA. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization upon request.	
Requestor Signature	Date:

Please ensure this form is filled out in its entirety to avoid delays in your accommodation.