Illinois Department on Aging
Reasonable Accommodation Request for Employees

Read this information first

The mission of the Illinois Department on Aging's (IDoA) Reasonable Accommodation Committee is to receive, research and approve, when appropriate, requests for reasonable accommodation covered under the Americans with Disabilities Act (ADA) and non-ADA covered requests substantiated with acceptable medical verification; and to conduct periodic follow-up reviews with the employees accommodated to assess that their needs have been met or determine if the accommodation is still required. This form must be completed if you are requesting accommodation (i.e., modifications to work sites, processes, or work schedules) as a person with a disability or substantiated medical condition to enable you to perform a particular job. All steps must be completed before your request will be considered.

Step 1: Identify yourself

Name: ____________________________________ Work Phone #: (____) _____-________

Job title: __________________________________ Division: _______________________________________

Address of worksite:____
Street address City State ZIP Code

Description of disability or limitations:

Step 2: Identify your request - check all that apply and provide requested information

❐ Modification(s) to equipment/devices (*e.g.,* ergonomic chair or keyboard, TDD telephone, computer monitor, braille equipment)

Describe:

❐ Restructuring job or task modifications (*e.g.*, temporary exemption from lifting, bending, reaching, travel)

Describe:

❐ Structural modification to work site (*e.g.*, handicapped accesses, assistive devices)

Describe:

❐ Modification to work schedule or leave policy (*e.g.*, temporary assignment to alternative work schedule, daytime driving, alternative leave intervals)

Describe:

❐ Modification of examinations, training materials or request for a personal assistant (*e.g.*, extra time, reader, sign language interpreter, braille materials, authorization for assistance animal in the work area)

Describe:

❐ Other

Describe:

Step 3: Sign here

____ _______/______/________
Requester's signature Month Day Year

Step 4: Complete your request

The next page must be completed and signed by your doctor **if requested by the agency**. If your doctor chooses to provide the information separately, all 5 parts are required to be completed and included in the doctor's statement. This form and any attachments must be forwarded to your immediate supervisor. *Keep a copy for your records.*

Requestor's name: ____________________________________

Medical practitioner's statement - Describe how the patient's medical condition interferes with performance of job duties or participation in activities sponsored by IDOA. **Each part below must be completed if the agency requests it.** Attach additional sheets if necessary.

Part a: ***Diagnosis.*** Patient's medical condition.

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Part b: ***Prognosis.*** Probable course/outcome of patient's medical condition and the likelihood of recovery.

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Part c: ***Duration of need.*** State whether the accommodation is needed temporarily or permanently. If temporary, state how long.

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Part d: ***Specific description of recommended accommodation.*** Exact description of what is needed to accommodate (*e.g.*, ergonomic chair or keyboard, modified job duties, changes required in work environment) patient's medical condition. Be specific and identify features needed (*e.g.*, chair with no arms, adjustable keyboard tray, no lifting over 10 lbs.).

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Part e: Practitioner's name (Please print)**:** ________________________ **Practitioner's license number:** ___________________

Practitioner's signature: _____________________________________ Date: ___/___/___ Phone :(_____) _____-________

Immediate supervisor: *Make a recommendation to the Division Manager within five (5) business days.*

Name: __________________________ Date received: ____/___/____ Date forwarded: ___/____/____

❒ Recommended ❒ Not recommended

Explanation: ____

Supervisor's signature: ____

Division Manager: *Make a recommendation within five (5) business days and return it to the Office of Human Resources.*

Name: __________________________ Date received: ____/___/____ Date forwarded: ___/____/____

❒ Recommended ❒ Not recommended

Explanation: ____

Manager's signature: ____

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Reasonable Accommodation Committee (RAC) Action

Case number assigned: ______________ Initial presentation date: ____/____/____

❒ Returned - Reason: ____

____ ___/___/___ ________________
Date Initials

❒ Denied - Explanation: ____

____ ___/___/___ ________________
Date Initials

❒ Approved: ADA accommodation____ Non-ADA accommodation____

____ ___/___/___ ________________
Date Initials