



Employee Request for Job Assistance/Accommodation

This form must be completed by an employee who is requesting job assistance or accommodation that exceeds or is expected to exceed 90 calendar days and must be provided to the Human Resource Officer for the organizational unit. The Human Resource Officer will send the request to the DOC Employee ADA Coordinator immediately upon receipt of all necessary information.

Name _____ Date of Request _____
Job Title _____ Work Location _____
Name and Job Title of Supervisor _____

Specific Assistance/Accommodation Requested: (This may include reassignment, job restructuring, equipment modifications or purchase, work schedule adjustments, etc.) Attach a separate page if necessary.

Medical Certification:

A statement from the health care provider outlining the need for accommodation must be attached. The employee signature on this form and completion of the *Authorization for Release of Information - Job Assistance/Accommodation 150_F3* authorizes the agency representative, normally the Human Resource Officer or the DOC Employee ADA Coordinator, to discuss the employee's work restrictions and physical or mental impairment with the attending health care provider. The statement from the health care provider must meet the following criteria for consideration. Failure to provide all and complete information may delay a decision on the request.

1. The documentation must be on the health care provider's official letterhead and state whether the physical or mental impairment is temporary or permanent. If temporary, an estimated date the impairment is expected to end must be provided.
2. The health care provider's credentials must be identified, i.e., M.D.
3. The documentation must be dated and signed by the health care provider.
4. The documentation must identify the specific physical or mental impairment that requires the accommodation.
5. The documentation must describe the specific limitations as they relate to the employee's job responsibilities and essential job functions.
6. The statement must indicate how the accommodation will assist the employee to perform the essential job functions.
7. If the purchase of equipment or any other item is recommended and if known, the health care provider should indicate where the equipment or item may be purchased and the approximate cost.
8. Any recommendation for work site modifications should specifically describe the necessary changes and impact of the changes on the employee's ability to perform the essential job functions.
9. If appropriate, the health care provider should indicate that there is no job assistance or accommodation that will enable the employee to perform the essential job functions. If reassignment to another position is a possibility, the statement should indicate what type of work the employee could perform.

Employee Certification:

I have attached the necessary information to support my request for assistance/accommodation, and I authorize a representative from the Virginia Department of Corrections as stated above to receive and discuss information from my health care provider, as identified below.

Name of Health Care Provider _____

Title of Health Care Provider _____

Telephone Number of Health Care Provider _____

I verify that all information provided is accurate and factual to the best of my knowledge and I understand that all information provided will be confidentially maintained in accordance with applicable law and policy.

Employee Signature _____ Date _____

