Arkansas Department of Finance and Administration

Reasonable Accommodation Request Form for Employees

All information regarding an individual's medical condition and the reasonable accommodation request is confidential and only disclosed to persons on a need to know basis. Any and all documents related to this request are kept confidential and will be maintained and used in accordance with applicable state and federal law.

Instructions: Individuals who are employed at the Arkansas Department of Finance and Administration (DFA) and are requesting a reasonable accommodation(s) under the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act, relevant state law, and accompanying state and federal regulations, are encouraged to complete this form in its entirety.

In order to explore possible coverage and reasonable accommodations, information is required regarding your medical condition, essential job functions, applicable functional limitations and your requested accommodation(s). It is often necessary for staff of the DFA Human Resources to discuss your medical condition and the documentation you submit to our office with providers such as licensed physicians, psychologists, or other qualified professionals. If you need help in completing this form, someone else may complete it on your behalf, or you may contact the ADA Coordinator for assistance at (501) 371-6009.

Upon completion, please forward this form, along with information from your qualified healthcare professional documenting your disability and the need for reasonable accommodation to the ADA Coordinator.

You may be asked to submit a list of specific questions to your health care or vocational professional. Please be sure you sign this form.

If you have questions, please call the DFA Human Resources Office at 501-371-6009.

☐ Employee ☐ Other (specify) _____

Name: _____
First Middle Last

Job Title: _____

Department: _____

Work Address: _____
City State ZIP Code

Work Telephone Number: _____

Work Email: _____

Home Address: _____
City State ZIP Code

Home Telephone Number: _____

Home Email: _____

Preferred method of contact: ☐ Home Phone ☐ Home Email ☐ Work Phone ☐ Work Email

How long have you worked in current position? _____

Administrator/Supervisor's Name:

_____
First Middle Last

Job Title: _____

Division: _____

Work Telephone Number: _____

Work Email: _____

Medical Information

Please identify the medical condition(s) for which you are requesting an accommodation.

Please provide the name and contact information for the health care professional who diagnosed the medical condition(s) listed above. Please include the date of diagnosis.

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Job and Accommodation Information

Please explain how your medical condition(s) listed above affects your ability to perform the essential functions of your position. If you are a new employee, state the anticipated difficulties you foresee in completing your job duties. Be as specific regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

Please provide your recommendations for a reasonable accommodation(s) and any information you may have about any associated costs (attach supporting documentation).

Please describe any accommodations or assistive technologies you currently use.

Please add any comments you feel may be helpful in consideration of your request.

Acknowledgement

I understand that it will be my responsibility to complete submit a list of questions to my medical professional, if required by DFA, and provide it to the DFA ADA Coordinator for my request to be evaluated. I further understand that the DFA ADA Coordinator will evaluate and respond to me based upon the information that I provide.

_____ _____

Employee Signature Date

□ Please check here if additional information is attached to this request.