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| ***This form is used by HR to document the Interactive Process when an employee requests an accommodation under the Americans with Disabilities Act or similar state law.*** |
| Name of HR Business Partner Reviewing Request: |  |
| Employee’s Name: |  |
| Employee’s Identification Number: |  |
| Employee’s Position (job title, department): |  |
| Employee’s Manager: |  |
| 1.) Describe how employee’s condition limits his/her ability to perform his/her job. |  |
| 2.) Describe the accommodation requested. Please be as specific as possible**.** |  |
| 3.) Explain how the accommodation(s) requested will enable the employee to perform his or her job. |  |
| 4.) If there is a cost associated with the accommodation, provide an estimate of the cost, if known. |  |
| 5.) If the employee receives the requested accommodation(s), will there be other aspects of the job that he or she will not be able to perform? |  |
| 6.) Does Medical Evaluation (or other health provider information submitted) support the employee’s requested accommodation? | Yes [ ]  No [ ] If no, explain: |
| 7.) Is the accommodation(s) temporary? | Yes [ ]  No[ ]  If yes, how long is the temporary accommodation anticipated to be required? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 8.) Was requested accommodation(s) granted?If the above response is “no”, was an alternative accommodation discussed?  | Yes [ ]  No [ ] Yes [ ]  No [ ]   |
| 9.) If an alternative accommodation was discussed, describe the accommodation with as much detail as possible. |  |
| 10.) Describe final accommodation offered to employee. |  |
| 11.) Was the final accommodation offered to employee accepted by employee? | Yes [ ]  No [ ]  |
| 12.) Review date for accommodation? |  |
| HR Business Partner Signature→ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |

**SEND COMPLETED FORM TO HR SERVICE CENTER FOR INCLUSION IN EMPLOYEE’S PERSONNEL FILE.**

**UPDATE SITE SPREADSHEET WITH INFORMATION ABOUT ACCOMMODATION REQUEST**

**NOTIFY EMPLOYEE’S SUPERVISOR/MANAGER OF ACCOMMODATION BY EMAIL USING ONLY THE LAST PAGE OF THIS FORM**

Notes:

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| Date: |  |
| Employee’s Name: |  |
| Employee’s Position (job title, department): |  |
| Employee’s Manager: |  |
| Accommodation Granted: |  |
| Review date for Accommodation: |  |

You are receiving this form to notify you that I have received a request for an accommodation under the Americans with Disabilities Act or similar state law. After review, I have approved the accommodation described above.

If you have any questions, please do not hesitate to contact me.

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| HR Business Partner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature |  |