RIVERSIDE COMMUNITY COLLEGE DISTRICT
DISABILITY ACCOMMODATION REQUEST FORM

To be completed by any employee who believes based on medical need he/she needs a reasonable accommodation(s):

Name (Last) (First) (Middle Initial)

Home Address City Zip Code Home Telephone

Work Location and Telephone Number Position Classification/Title

Supervisor's Name and Title

Have you discussed your request with your supervisor?
☐ YES ☐ NO

Medical Verification

Please attach your medical note to this form and redact any information regarding medical diagnosis/condition and/or treatment plan. A medical note is required to complete processing of this request.

Is your request for a temporary* or permanent accommodation? ☐ Temporary ☐ Permanent
**temporary is typically for conditions expected to last less than six (6) months.*

Please state the medical restrictions provided by your doctor and describe how those restrictions may impact your performance of assigned duties. Please identify specific tasks, activities, etc. and how they may be affected. Also, state any specific accommodations that you believe would allow you to perform the essential functions of your job. *(If necessary, attach additional pages.)*

PLEASE READ AND ACKNOWLEDGE:

All employee accommodation and medical information will be maintained by the office of Diversity & Human Resources, separate from the personnel information and is regarded as confidential.

Employee requests for temporary accommodation of functional limitations / work restrictions can take five (5) working days or more for processing and must be approved by supervisors based on operational need. During the period of time it may take to identify temporary modified work, the employee may be required to remain off work utilizing available paid leaves (Sick, Vacation, Extended Illness Leave)

I understand that the District may engage in a good-faith Interactive Process which may or may not require an accommodations meeting.

I certify that all the information contained in this application is true and correct. I understand that if I an accommodation is arranged that is subsequently determined to be based upon misrepresentation or falsification, I may be subject to disciplinary action and/or my request will be canceled.

_____ _____

Signature of Employee Date

Submit this completed form to the Office of Diversity, Equity and Compliance,
Attention: Georgina Villaseñor, 450 E. Alessandro Blvd. Riverside, CA 92505
E-mail: georgina.villasenor@rccd.edu
Fax: (951) 222-8037
Should you have any questions, please contact (951) 328-3725.

For Official Use Only

Completed form & medical verification received in DHR:

Accommodation discussion(s) with supervisor:

Accommodation discussion(s) with employee:

Requests for medical clarification:

IP Meeting Date(s):

Approval:

Description and anticipated duration of accommodation:

Accommodation ended (attach medical clearance note):