RIVERSIDE COMMUNITY COLLEGE DISTRICT
DISABILITY ACCOMMODATION REQUEST FORM

This form can be completed by any employee who believes based on medical necessity they require a reasonable accommodation(s):

Name (Last) (First) (Middle Initial)

Home Address City Zip Code Contact Phone Number

Work Location Position Classification/Title

Supervisor's Name

Have you discussed this request with your supervisor?
○ YES ○ NO

Is this request for a temporary* or permanent accommodation? ○ Temporary ○ Permanent
**a temporary accommodation is typically less than six (6) months.*

Please describe how the functional limitations provided by your medical provider may affect your performance in your current position including the specific duties, tasks, activities, etc. You may need to refer to your job description. Also indicate any specific accommodations you believe would allow you to perform the essential functions of your job. *(If necessary, attach additional pages.)*

Medical Verification

A medical note outlining functional limitations and/or work restrictions from your medical provider is required to process this request. Please attach your medical note and redact any medical diagnosis/ condition and/or treatment plan information.

PLEASE READ AND ACKNOWLEDGE:

All employee accommodation information is kept in the Office of Human Resources & Employee Relations separate from the personnel file, and regarded as confidential. Please do not provide documentation containing medical diagnosis, condition, or treatment information.

Employee requests for accommodations are evaluated on a case-by-case basis. Although the preferred accommodation indicated on this form may not be granted, the District is committed to engaging in a good-faith interactive process with you to consider all reasonable accommodations. Clear functional limitations and/or work restrictions from your medical provider are required to engage in this process. During the period of time it may take to clarify information or identify accommodations, you may be required to remain off work utilizing available personal paid leaves including sick, vacation, and extended illness leave.

I certify that all the information contained in this request form is true and correct. I understand that if an accommodation is provided and subsequently determined to be based upon misrepresentation or falsification of information, my request will be canceled.

_____ _____

Employee Signature Date

Submit this completed form to the Office of Human Resources & Employee Relations,
Attention: Georgina Villaseñor-Lee, 3801 Market St. Riverside, CA 92501
E-mail: Georgina.Villasenor-Lee@rccd.edu
Fax: (951) 222-8831
Should you have any questions, please contact (951) 328-3725.

For HRER Use Only:

Completed form received:

Medical verification received:

Contact with supervisor:

Contact with employee:

Requests for medical clarification:

IP Meeting: