



CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT

Office of Human Resources
Accommodation Request Form



This form must be completed in order for a qualified disabled employee of the District to formally request a reasonable accommodation(s). Your request will be processed as confidential in accordance with applicable law. As the employer, the District is ultimately responsible for determining what a reasonable accommodation is by reviewing all of the pertinent information and the needs of each employee on a case-by-case basis.

Your request for reasonable accommodations will be reviewed and you will be notified by the District's decision in a reasonable time after this form is received by the ADA Coordinator (Human Resources - Benefits Office).

PERSONAL INFORMATION: (The following to be completed by the employee)

Date: \_\_\_\_\_

Location: [ ] Chabot College [ ] Las Positas College [ ] District Office

Faculty

[ ] Full-time (Regular)
[ ] Part-time

Classified

[ ] Full-time (Regular)
[ ] Confidential
[ ] Supervisory

Management

[ ] Administrator

(Please Print)

Name: \_\_\_\_\_
(Last) (First) (MI)

W #: \_\_\_\_\_

Residential address: \_\_\_\_\_
(Street Address / Apt #) (City) (State/Zip)

Phone #: (\_\_\_\_\_) \_\_\_\_\_ Alternate phone #: (\_\_\_\_\_) \_\_\_\_\_

Current Position: \_\_\_\_\_ Division/Dept: \_\_\_\_\_

REASONABLE ACCOMMODATION REQUEST

What type of accommodation(s) do you need?

- [ ] Modified work schedule [ ] Removal of communication barrier [ ] Job Restructuring
[ ] Change in procedure [ ] Purchase of assistive services [ ] Reassignment
[ ] Purchase assistive device [ ] Removal of architectural barrier [ ] Other

Please describe the accommodations requested: (use extra sheets if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain how you believe this accommodation will enable you to perform the essential functions of your position: (use extra sheets if needed)

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### ESSENTIAL DUTIES OF YOUR POSITION

Please identify the essential duties (do not include marginal duties) of your position for which you are requesting an accommodation:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### HEALTH CARE PROVIDER (Fill this out if the District deems your verification of the disability to be insufficient)

Please provide us with the name of your health care provider(s) who can assist with this request: (use extra sheets if needed) (written permission must be granted for us to contact)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (\_\_\_\_\_) \_\_\_\_\_ Specialty: \_\_\_\_\_

### MAJOR LIFE ACTIVITIES

Please check the major life activity(ies) you believe to be limited by your medical condition(s):

- |                                  |                                    |                                  |  |                                  |
|----------------------------------|------------------------------------|----------------------------------|--|----------------------------------|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Breathing | <input type="checkbox"/> Seeing  | <input type="checkbox"/> Caring for Oneself      | <input type="checkbox"/> Talking |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Learning  | <input type="checkbox"/> Working | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Other   |

Please describe how the above activity(ies) is/are limited:

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Is your medical condition temporary?  Yes  No

If yes, please state the expected duration:

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Are you currently working?  Yes  No

If no, please specify the type of leave currently approved and when do you expect to return to work?

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I hereby certify that I believe I am a qualified individual with a disability as defined by the law. I have received and reviewed the information brochure and require an accommodation to perform the essential functions of my position. I understand that a detailed review of my disability status may be required, and I agree to cooperate fully in this process. I further understand that if my request is granted, I am obligated to report any changes in my disability status which may require a re-evaluation of this request. Granting of this request does not signify approval of any future reasonable accommodation request for any other position within the District or if applicable, any department within the County of Alameda.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Return this completed form to:**

**Human Resources – Benefits Office  
Chabot-Las Positas Community College District  
7600 Dublin Boulevard, 3<sup>rd</sup> Floor  
Dublin CA 94568**

**For additional information, please contact the Human Resources, Benefits Office at (925) 485-5505.**

*Reference:* Article 9M.1 – Faculty Collective Bargaining Agreement