

REASONABLE ACCOMMODATION REQUEST FORM  
(Please forward initially to the ADA Coordinator of your Agency)

NAME: \_\_\_\_\_ Day Phone # (VOICE ) \_\_\_\_\_  
Please print - Last Name, First Name, MI (TDD/TTY) \_\_\_\_\_ Soc Sec Number \_\_\_\_\_

Current Title in State Government( if applicable): \_\_\_\_\_  
Classification Title (Offered): \_\_\_\_\_

I am an applicant/employee for the position named above and may require a "reasonable accommodation" to perform the essential function(s) of the job. I hereby request that the ADA Coordinator and/or other individuals identified in the Reasonable Accommodation Rule/Policy of the State of Rhode to contact me regarding this need for reasonable accommodations and authorize them to verify this request. I do hereby waive my rights of confidentiality of information (medical/personnel or otherwise) so that pertinent information will be forwarded to other departments for processing. I understand that I have a right to appeal the decision of the ADA Coordinator noted below. Upon appeal, a job analysis, by the Office of Rehabilitative Services or its designated vendor, will be completed and a recommendation made within 60 calendar days of the receipt of such request.

PLEASE DESCRIBE BELOW THE ACCOMMODATION YOU MAY NEED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I AUTHORIZE \_\_\_\_\_ TO RELEASE MY MEDICAL RECORDS TO VERIFY MY NEED FOR  
(Health Professional's Name) A REASONABLE ACCOMMODATION DUE TO MY DISABILITY.

Health Professional's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_

Applicant/Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Union Official Signature/Title (if necessary) \_\_\_\_\_ Date \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE

1. Agency ADA Coordinator/ Appt. Auth. Response \_\_\_ Approved \_\_\_ Not Needed \_\_\_ Denied

Authorized Name (Print) \_\_\_\_\_ Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

2. Office of Rehabilitative Services Response \_\_\_ Approved \_\_\_ Not Needed \_\_\_ Denied

Authorized Name (Print) \_\_\_\_\_ Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

3. ADA Equipment Committee Response \_\_\_ Approved \_\_\_ Not Needed \_\_\_ Denied

Authorized Name (Print) \_\_\_\_\_ Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

4. If Workers' Compensation Disability:  
Workers' Compensation Response \_\_\_ Approved \_\_\_ Not Needed \_\_\_ Denied

Authorized Name (Print) \_\_\_\_\_ Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

PLEASE COMPLETE REVERSE SIDE ONCE ACCOMMODATION HAS BEEN APPROVED

**Description of Approved Reasonable Accommodation**

**APPROVED BY:**  
Appointing Authority

\_\_\_\_\_  
Name (Please print)

\_\_\_\_\_  
Agency (Please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**ACCEPTED BY:**  
Employee/Applicant

\_\_\_\_\_  
Name (Please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Union Official Signature/Title (if necessary)

\_\_\_\_\_  
Date

Forward a copy of this Approved Reasonable Accommodation form to:  
**STATE ADA COORDINATOR,  
STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
GOVERNOR'S COMMISSION ON DISABILITIES  
John O. Pastore Center,  
41 Cherry Dale Court  
Cranston, RI 02920-3049  
[voice] (401) 462-0102 [tty/tdd] via RI Relay 711 [fax] (401) 462-0106  
[e-mail] bcooper@gcd.ri.gov [website] www.disabilities.ri.gov**