To be completed by employee.

EMPLOYEE'S
REQUEST FOR REASONABLE ACCOMMODATION

In accordance with the Americans with Disabilities Act (ADA), I am requesting that the City of Little Rock (hereafter the "City") make reasonable accommodation to enable me to perform the essential functions of the _____ position.

(Please check one) ☐ I currently hold the above stated position.
☐ I am a candidate for the above stated position.

Name: _____ Employee Number: _____
(Please Print)

Address: _____

Home Phone: _____ Work Phone: _____

NOTE: The information provided in the spaces below will enhance, and hopefully expedite, the process of identifying and implementing a reasonable accommodation. Therefore, it would be most beneficial for you to be as thorough as possible. Please attach additional sheets if necessary.

Please describe the nature of your impairment (attach supporting medical documents):

_____

_____

_____

Please describe precise job related limitation(s) imposed by the condition (specific to the position in question):

_____

_____

_____

Please suggest, as precisely as possible, the accommodation which you believe would best serve the needs of you and the City: _____

_____

_____

_____

_____ _____
Signature of Requestor Date

_____ _____
Labor & Employee Relations Designee Date Received

cc: Human Resources: Labor and Employee Relations Division

Revised 01-31-18

To be completed by your
Health Care Provider

CITY OF LITTLE ROCK – REASONABLE ACCOMMODATION HEALTH CARE PROVIDER CERTIFICATION FORM

Return completed form to Fax (501) 244-5475, Attention: Labor and Employee Relations Division

EMPLOYEE NAME: _____

JOB TITLE: _____

DATE ACCOMMODATION REQUEST RECEIVED: _____

1) Please review the attached job description. Is the employee able to perform the essential job functions of this position without reasonable accommodation?

Yes No (Please Circle One) - If Yes, no other questions will need to be completed. Please just sign the form and return to the fax number at the top of the page.

2) Does the employee have a physical or mental disability that will interfere with performing one or more of the essential functions of this position?

Yes No (Please Circle One) - If Yes, please describe how the physical or mental disability will interfere with the employee's ability to perform the essential job functions.

_____

_____

_____

_____

3) What reasonable accommodation(s) to the work requirements or position responsibilities would enable the employee to perform the essential functions of that position?

_____

_____

_____

_____

4) How long will the employee need the reasonable accommodation? If unable to provide a date, when will he or she be medically reevaluated?

_____

Please attach any additional documentation, comments, or suggestions.

_____ _____
Health Care Provider Name (Printed) Date

_____ _____
Health Care Provider Signature Telephone Number

Revised 10-29-2018

CITY OF LITTLE ROCK – REASONABLE ACCOMMODATION SUPPLEMENTAL INFORMATION FORM

Return completed form to Fax (501) 244-5475, Attention: Labor and Employee Relations Division

EMPLOYEE NAME: _____

JOB TITLE: _____

Please list any additional comments, concerns, or suggestions.