APPLICANT / EMPLOYEE REQUEST FOR REASONABLE ACCOMMODATION

HUMAN RESOURCES 501 N THOMPSON #400 CONROE, TX 77301 936-539-7886 FAX 936-788-8396

This form should be completed when an applicant or employee has indicated his / her desire to request a reasonable accommodation from the County. Upon completion, this form must be delivered to the Human Resources Department and kept separate from the applicant's / employee's personnel file.

Purpose: To assist the County in determining whether or to what extent a reasonable accommodation is required for an applicant / employee to safely and effectively perform the essential functions of his / her present job or the job he / she is seeking.

Date of Request:	**Position Applying For or Current Dept:**

Applicant / Employee's Name:

Applicant / Employee's Telephone Number:

BRIEFLY IDENTIFY AND DESCRIBE THE PHYSICAL OR MENTAL DISABILITY, ILLNESS, CONDITION OR DISEASE WHICH IS THE BASIS FOR YOUR REQUEST FOR REASONABLE ACCOMMODATION(S):

_____

_____

_____

IDENTIFY AND DESCRIBE THE ESSENTIAL FUNCTION(S) OF YOUR JOB OR THE JOB YOU ARE SEEKING WHICH YOU ARE UNABLE TO PERFORM WITHOUT 'REASONABLE ACCOMMODATION(S)' BY THE COUNTY:

_____

_____

_____

IDENTIFY AND DESCRIBE THE REASONABLE ACCOMMODATION(S) NEEDED TO ENABLE YOU TO PROPERLY AND SAFELY PERFORM THE ESSENTIAL FUNCTIONS OF YOUR JOB OR THE JOB YOU ARE SEEKING, INCLUDING SPECIAL EQUIPMENT, CHANGES IN THE PHYSICAL LAYOUT OF THE JOB, OR OTHER ACCOMMODATIONS:

_____

_____

_____

IDENTIFY AND DESCRIBE ANY SPECIAL METHODS, SKILLS OR PROCEDURES WHICH WOULD ENABLE YOU TO PERFORM THE ESSENTIAL FUNCTIONS OF YOUR JOB OR THE JOB YOU ARE SEEKING:

_____

_____

_____

IDENTIFY AND DESCRIBE ANY EQUIPMENT, AIDS, OR SERVICES THAT YOU ARE WILLING TO PROVIDE AND UTILIZE:

_____

_____

_____

IDENTIFY THE NAMES AND ADDRESSES OF PHYSICIANS, THERAPISTS, PSYCHOLOGISTS, OR OTHER HEALTH CARE PROVIDERS WHO HAVE INFORMATION OR DOCUMENTATION CONCERNING YOUR DISABILITY, ILLNESS, CONDITION, OR DISEASE OR YOUR NEED FOR A REASONABLE ACCOMMODATION BY THE COUNTY:

_____

_____

_____

I CERTIFY THAT I HAVE READ AND REVIEWED THE JOB DESCRIPTION FOR MY JOB OR THE JOB I AM SEEKING AND/OR HAVE BEEN INFORMED OF THE ESSENTIAL FUNCTIONS OF MY JOB. I FURTHER CERTIFY THAT THE FOREGOING STATEMENTS ARE COMPLETE, ACCURATE, AND TRUE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THE COUNTY MAY REQUIRE ME TO UNDERGO TESTING OR EVALUATION BY MEDICAL PERSONNEL RETAINED BY THE COUNTY FOR THE PURPOSE OF ESTABLISHING THE EXISTENCE AND EXTENT OF MY DISABILITY, ILLNESS, CONDITION, OR DISEASE AND MY ABILITY TO PERFORM ESSENTIAL JOB-RELATED FUNCTIONS WITH OR WITHOUT REASONABLE ACCOMODATION.

APPLICANT / EMPLOYEE SIGNATURE_____**DATE**_____