

REQUEST FOR REASONABLE ACCOMMODATION

The information requested below is **confidential** and will be used to determine an appropriate reasonable accommodation for your work-related limitations due to a qualifying disability or medical condition. The Air Resources Board (ARB) is responsible for determining the reasonable accommodation after reviewing all pertinent information on a case-by-case basis.

1. The following is to be completed by employee or a representative acting on behalf of the employee, and provided to the immediate supervisor or the Reasonable Accommodation Coordinator:

Name (please print or type): _____

Division/Branch: _____

Physical Work Address: _____

City/State/Zip: _____

Work Telephone No.: _____ Email Address: _____

Current Classification: _____

Supervisor's Name: _____ Telephone No.: _____

2. Is your disability or medical condition:

Permanent Temporary Undetermined

If temporary, please state the anticipated recovery date: _____

3. Major Life Activities:

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

Walking Breathing Seeing Working Talking
 Hearing Learning Performing Manual Tasks Other _____

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

4. Reasonable Accommodation Request:

What type of proposed accommodation are you requesting?

Architectural Changes Jobsite Modification Support Services
 Job Restructuring Equipment and/or Assistive Devices Modified Work Schedule
 Reassignment Other _____

If "other", please describe the proposed accommodation you are requesting: (Attach additional sheets if necessary.)

5. Essential Duties of Your Position:

Please review your current duty statement and identify the essential duties (do not include marginal duties) of your position that you believe are problematic due to your disability or medical condition. (Attach additional sheets if necessary.)

- a. _____
- b. _____
- c. _____
- d. _____

6. Please describe how the proposed accommodation would allow you to perform the essential functions of your job:
(Attach additional sheets if necessary.)

7. Health Care Professional and Verification:

You are not required to provide a statement from your treating health care professional at this time. You may do so now, or ARB may request information from your treating health care professional later in the process. If ARB requests information from your treating health care professional, ARB will not ask that your disability (diagnosis) be disclosed, only what your restrictions are and recommendations for accommodations.

The medical documentation must be dated and written on official letterhead. The treating health care professional must be identified (e.g., M.D., D.O., D.C.) and the documentation signed by the treating health care professional.

The treating health care professional must review the employee's current duty statement and identify how the accommodation will allow the employee to perform the essential duties of the job (i.e., specific equipment or services). (Attach additional sheets if necessary.)

8. I believe I am a qualified individual with a disability*. I am requesting a reasonable accommodation, which will allow me to perform the essential functions of my position as described above.

Employee Signature _____ *Date*

9. A supervisor receiving this form must transmit it confidentially to the Reasonable Accommodation Coordinator immediately. Within five business days of receiving the employee's signed request, the Reasonable Accommodation Coordinator will acknowledge the employee's request in writing. The written acknowledgement will include a date and time to meet with the employee to begin the interactive process. The meeting will be set no later than 20 business days after the date the Reasonable Accommodation request was received by the Reasonable Accommodation Coordinator.

If ARB does not respond to your request within 20 business days or if your reasonable accommodation request is denied, you have a right to file an internal appeal with the Deputy Executive Officer for your division. Within 30 days from the receipt of the denial, you may file a written appeal with the State Personnel Board's Appeals Division, 801 Capitol Mall, Sacramento, California 95814. An appeal may also be filed concurrently with the California Department of Fair Employment and Housing and/or the United States Equal Employment Opportunity Commission. Employees have the right to pursue an external agency process at any time during the internal ARB process.

Please provide the signed original Request for Reasonable Accommodation form and any medical documentation (if applicable) in a confidential envelope to:

Air Resources Board - Management Services Branch
PO Box 2815, Sacramento, California 95812
Attn: Reasonable Accommodation Coordinator

*You are not required to disclose what your disability is (diagnosis), only what your restrictions are.