San Diego State University  
Office of Employee Relations & Compliance  
REQUEST FOR REASONABLE ACCOMMODATION

EMPLOYEE REQUEST

Employee Name ______________________________________________________________________

Working Title __________________________________ Classification__________________________

Phone ____________________________ Department________________________________________

Supervisor ______________________________ Title________________________________________

Phone ___________________________________ Fax _______________________________________

1. I am requesting an accommodation for the following reason:

___ I am applying for employment and a reasonable accommodation is necessary in order to comply
with your application procedures.

___ I am currently employed by SDSU and am requesting a reasonable accommodation in order to
perform the essential functions of my existing position.

2. Summarize the primary job responsibilities and attach a current copy of the position description
in which you are currently employed or for the position that you are interested in apply for.
(Please contact The Center for Human Resources, if you need a copy of a position description.)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
3. Describe the essential functions of the position for which assistance is being requested. (e.g. reading, writing, driving, lifting, typing)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4. Describe any accommodations which you believe are necessary to allow you to effectively perform the essential functions of the position.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

5. If accommodation is time sensitive, please explain:

______________________________________________________________________________

I certify that the information provided above is true and correct to the best of my knowledge.

______________________________________________________________________________

Employee Signature Date

*Fill out and sign the Authorization for Release of Medical Information found on the next page.*
I hereby authorize the release of medical information regarding the limitations I have described in the attached Request for Reasonable Accommodations form. This authorization is limited to the details provided below:

1. Name, address and telephone number of treating physician authorized to release information:
   ___________________________________________________________________________
   ___________________________________________________________________________

2. This information will only be released to those persons who have a business need to know in order to evaluate this request.

3. I authorize the release of any medical information necessary to evaluate my ability to perform the essential functions of the job in question.

4. This information shall be used solely for the purpose of determining reasonable accommodations for my disability.

5. This authorization shall remain valid for as long as the need for an accommodation remains necessary.

I understand that I have the right to receive a true copy of this authorization. By my signature at the bottom of the original authorization, I hereby acknowledge that I have received a true copy of this authorization.

Employee Signature: _____________________________ Date: ______________
SUPERVISOR’S REVIEW

1. Identify the essential and non-essential functions of the position and analyze the job requirements after consulting with employee/applicant and reviewing functional limitations.

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____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

2. Identify position related limitations.

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____________________________________________________________________________
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3. Identify possible reasonable accommodation.

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____________________________________________________________________________
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4. Assess whether the proposed accommodation poses an undue hardship.

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____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
5. Do you concur with the statements made by the employee and/or do you want to add any additional information?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Supervisor’s Signature _______________________________ Date _______________________________

Title ____________________________________________

DEAN/DIRECTOR

1. Do you concur with the statements made by the employee and/or do you want to add any additional information?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Dean/Director Signature __________________________ Date __________________________

Title ____________________________________________
MEDICAL REVIEW
(to be completed by employee’s physician)

Please refer to the employee’s Authorization for Release of Medical Information found on the last page prior to responding.

Employee is currently able to perform all job functions described in the attached job description without posing a direct threat to the safety of self or others

☐ Yes  ☐ No

If no, employee has the following limitations in relations to described job functions.

Functional Limitation:

(Please be specific as to each limitation and its expected duration)¹

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Physician’s Signature                                          Date

¹ NOTICE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
FINAL ACTION

Accommodation approved?  □ Yes  □ No

If yes, describe accommodation and duration:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
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If no, explain:  ____________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

_______________________________________________      _______________________________
Supervisor’s Signature                          Date

_______________________________________________      _______________________________
Dean/Director                                      Date