Workplace Accommodation Request

If you believe that you are eligible for workplace accommodation(s) please complete this form and return it to the Human Resources Office.

The information you provide in this form will be used to prepare for a meeting with you to discuss your accommodation requirements. It is important to understand that any medical information gained during this process will be kept confidential in HR. Only essential information pertaining to your condition, the feasibility of the requested accommodation(s), logistics, and agreements, if any, will be discussed with your supervisor on a need to know basis.

After HR reviews your information, we will contact you to confirm your eligibility for workplace accommodations and, if eligible, will - in collaboration with your supervisor - engage in an interactive process with you to determine options for workplace accommodation(s) that are both consistent with District needs and support your efforts to safely and successfully perform the essential functions of your role.

If you have any questions not addressed in this form, please contact: Nikki Tucker, Director of Human Resources at Nikki.Tucker@woodburnsd.org

Employee Name: _____

Job Title: _____

Department/Location: _____

1. **What is the diagnosis of the condition causing you to request an accommodation?**

2. **Functional Limitations(s) - Please explain the workplace limitations you experience as a result of your disability or medical condition and how those limitations impact your ability to safely and/or successfully perform your job duties. Be as specific as possible.**

3. **Please list specific accommodations you are interested in exploring?**

4. **How will the accommodations(s) you are interested in exploring support your ability to safely and/or successfully perform your job duties?**

I authorize my treating provider to communicate with and provide information to Woodburn School District for the purpose of determining a reasonable accommodation to enable me to perform the essential functions of my job.

Employee Signature: _____ Date: _____

Human Resources will schedule an appointment with you after the additional medical provider verification form is also received in the Human Resources department.