REASONABLE ACCOMMODATION REQUEST FORM

A Medical Certification will be required to support your request. Provide the "Medical Inquiry Form in Response to an ADA Reasonable Accommodation Request" to your medical provider to complete it and return it to HR at HRBenefits@kentwa.gov or by fax at 253.856.6270.

Name: Last First	Department
Job Title	Supervisor Name

1. Do you have a physical or mental impairment that substantially limits one or more major life activities (i.e., working, talking, seeing, breathing, hearing, caring for oneself?) YES ☐ NO ☐
2. Describe the limitations resulting from your medical condition and what if any essential functions of your job are you having difficulty performing? What, if any, benefits of employment are you having difficulty accessing?
3. How is your limitation(s) interfering with your ability to perform the essential functions of your job?
4. What specific accommodation are you seeking? Has a health care professional recommended a specific accommodation?
5. If you are requesting a specific accommodation, how will that accommodation assist you in performing the essential functions of your job?
6. Expected duration of Disability:
7. Have you had any accommodations in the past for this limitation? If yes, what were they and how did the accommodation(s) help you perform your job?
8. Please provide any additional information that might be useful in processing your accommodation request. We will set up a time to meet with you and your supervisor to discuss your request as soon as the "Medical Inquiry Form in Response to an ADA Reasonable Accommodation Request" is received from your medical provider.

Attach additional pages, if necessary. **Return form to HRBenefits@kentwa.gov**

Employee's Signature	Date

Received in HR by: Received in HR date: