CUI//SP-PERS

FEDERAL MEDIATION AND CONCILIATION SERVICE
250 E Street, SW
Washington, D.C. 20427

Reasonable Accommodation Request Form

CONFIDENTIAL

Please complete this form if you have a physical or mental health disability and need a reasonable accommodation to perform the essential functions of your position or to participate in the hiring process. Should you need any help completing this form, or if you have any questions about this form or FMCS's reasonable accommodation policy, please speak to the Reasonable Accommodation Coordinator (RAC) at (202) 606-5465. This form should be returned directly to the RAC, 250 E Street, SW, Washington, DC 20427, Attention: Natalie C. Samuels OR E-mail to FMCSMedicalInfo@fmcs.gov . FOR CURRENT EMPLOYEES, THIS FORM SHOULD NOT BE RETURNED TO YOUR MANAGER OR TO ANYONE AT YOUR LOCATION.

EMPLOYEE/APPLICANT NAME: _____

DEPARTMENT: _____

LOCATION: _____

POSITION: _____

1. Please describe the accommodation(s) you are requesting. If there is more than one accommodation that you believe will meet your needs, please describe all possible accommodations.

2. Please describe your medical condition and the reason(s) why you are requesting an accommodation. For current employees, include a description of the essential functions of your job that you currently are unable to perform, and explain how the requested accommodation(s) will enable you to perform those essential functions of your job.

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Employee/Applicant Name:_____

3. For how long the requested accommodation(s) will be needed. _____

4. Please attach to this form any documentation that you believe supports your need for the requested reasonable accommodation. Please also provide any other information that you believe is relevant to your request.

I certify that the information contained on this form and submitted with this form is true and correct.

_____ _____
Signature *Date*

Privacy Act Statement. 29 U.S.C. 172, et seq. The Rehabilitation Act of 1973, United States Code - 29 U.S.C. § 791; The Americans with Disabilities Act of 1990, 42 U.S.C. § 12101; Title VII of the Civil Rights Act, 42 U.S.C. § 2000e-16; the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601; 40 U.S.C. § 3173; Executive Order - E.O. 13164 (July 28, 2000); E.O. 13548 (July 26, 2010); E.O. 14042 (September 9, 2021); and E.O. 14043 (September 9, 2021) authorize the FMCS to collect this information. The primary use of the information on this form is to facilitate the reasonable accommodation process. Additional disclosures of the information on this report may be made: (1) to a Federal, State, or local law enforcement agency if FMCS becomes aware of a violation or potential violation of law or regulation; (2) to a court or party in a court or Federal administrative proceeding if the Government is a party or in order to comply with a judge-issued subpoena; (3) to the National Archives and Records Administration or the General Services Administration in record management inspections; (4) to the Office of Management and Budget during legislative coordination on private relief legislation; and (5) in a judicial or administrative proceeding if the information is relevant to the subject matter; (6) to the Equal Employment Opportunity Commission through their mandatory reports. This confidential information will not be disclosed to any requesting person unless authorized by law. Failure to provide the requested information could result in FMCS's delay or inability to facilitate the reasonable accommodation process

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CERTIFICATION OF HEALTH CARE PROVIDER FOR REASONABLE ACCOMMODATION

Patient's Name: _____

Date Condition Commenced: _____

Probable Duration of Condition: _____

This certification will be used for the purpose of assessing whether your patient has a disability that would benefit from a reasonable accommodation within the workplace. Please base your assessment on your patient's present abilities or limitations in performing the essential functions of his/her current position as described to you.

1. Does your patient have a disability?[1] ☐ Yes ☐ No

2. If you answered "yes" to question #1, is your patient able to perform each of the essential job functions described **without** reasonable accommodation(s)? ☐ Yes ☐ No

3. If you answered "no" to question #2, would your patient be able to perform each of the essential job functions described **with** reasonable accommodation(s)? ☐ Yes ☐ No

4. If you answered "yes" to question #3, please provide the following information: a) state which essential function(s) of the job require an accommodation; b) for each such essential function, any recommendations you have for reasonable accommodation(s). If there is more than one recommended accommodation, please describe all possible accommodations; c) explain why the disability requires this accommodation to allow the employee to perform the essential function(s).

_____

_____

_____

[1] A disability is a condition that imposes a substantial limitation on a major life activity. By way of example, "major life activities" include, but are not limited to, standing, sitting, walking, lifting, talking, interacting with others, eating, breathing, hearing, seeing, speaking, working, and learning.

Disability also means a physical disability, infirmity, malformation or disfigurement which is caused by bodily injury, birth defect or illness including epilepsy and other seizure disorders, and which shall include, but not be limited to, any degree of paralysis, amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment or physical reliance on a service or guide dog, wheelchair, or other remedial appliance or device, or any mental, psychological or developmental disability resulting from anatomical, psychological, physiological or neurological conditions which prevents the normal exercise of any bodily or mental functions or is demonstrable, medically or psychologically, by accepted clinical or laboratory diagnostic techniques. Disability shall also mean AIDS or HIV infection.

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Patient/Employee's Name:_____

_____

_____

_____

Print or type clearly the name and address of the Health Care Provider completing this form:

Name: _____

Address: _____

_____

Telephone: _____

Facsimile: _____

E-mail Address:_____

_____ _____
Signature of Health Care Provider Date

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