

Reasonable Accommodations Policy and Procedure

State of Maryland
Reasonable Accommodation Employer Review Form
CONFIDENTIAL

Employee or Applicant Name:	Job Title:
Daytime Phone #	Address:
Employee: <input type="checkbox"/> Applicant: <input type="checkbox"/>	Request Date:
Describe disability and functional limitations: _____ _____ _____	
Describe accommodation being requested and purpose for request: _____ _____ _____	
List essential functions of position and indicate whether the employee can perform the function with the requested accommodation: 1. _____ Yes ___ No ___ NA* ___ 2. _____ Yes ___ No ___ NA ___ 3. _____ Yes ___ No ___ NA ___ 4. _____ Yes ___ No ___ NA ___ *Accommodation not necessary to perform this function. (Attach additional pages if necessary)	
Was medical information provided? If yes, indicate by whom, and identify who reviewed medical information. _____	
Describe steps taken to evaluate effectiveness and feasibility of requested accommodation. _____ _____ _____	
Accommodation request is: Approved ___ Denied ___ Modified ___ If APPROVED, indicate what accommodation will be provided. If MODIFIED, describe modification and provide reason. If DENIED, complete section below. _____ _____	
IF REQUEST WAS DENIED, check reasons for denying the accommodation request. You may check more than one reason. <input type="checkbox"/> The individual did not provide documentation of a disability that substantially limits a major life activity. <input type="checkbox"/> The requested accommodation is ineffective (will not enable individual to perform the essential functions of the position).	

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- The individual's disability/limitations do not prevent him/her from performing the essential functions of the position.
- The accommodation/modification request will:
 - create an undue administrative burden
 - create an undue impact on operations
 - fundamentally alter the nature or operation of the facility
 - require lowering of current performance standard(s)
- An effective accommodation that would not pose an undue hardship was offered but rejected by the individual.

Name of person making the decision:	ADA Coordinator:
<hr/>	<hr/>
Print Name	Print Name
<hr/>	<hr/>
Signature	Signature
Date	Date

Submit a copy of this form to the Office of the Statewide EEO Coordinator with the Agency Case Tracking Form.