FOOTHILL-DE ANZA
Community College District

Foothill-De Anza Community College District
District Office of Human Resources
12345 El Monte Road, Los Altos Hills, CA 94022
Attn: Director of Benefits

REQUEST FOR EMPLOYMENT RELATED ACCOMMODATION Under the AMERICANS WITH DISABILITIES ACT and CALIFORNIA FAIR EMPLOYMENT AND HOUSING ACT

Last Name ____________ First Name ____________ Employee CWID ____________

Campus ____________ Department/Division ____________ Phone/Contact Number ____________

Name of Supervisor/Dean ____________ Email ____________ Phone ____________

It is the policy of Foothill-De Anza Community College District (FHDA) to provide reasonable accommodation for qualified individuals with disabilities in accordance with the Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA). You may be required to provide documentation in support of your request.

1. Current Position:

Title: ____

2. Reasonable Accommodation Request

What type of accommodation are you requesting?

☐ Modified work schedule
☐ Change in procedure
☐ Removal of architectural barrier
☐ Removal of communications barrier
☐ Purchase of assisting devices
☐ Purchase of assisting services
☐ Job restructure
☐ Reassignment
☐ Other

Please describe the requested accommodation:

Please explain how you believe this accommodation will enable you to perform the fundamental functions of your position:

3. Fundamental/Essential Job Duties of Your Position

Please identify the essential/fundamental job duties (do not include marginal duties) of your position *for which you are requesting accommodation*. Attach additional pages if necessary.

1. ____
2. ____
3. ____

4. Physician/Medical Provider

Please provide us with the name of your health care provider(s) who can assist with this request. If you have additional providers who also have information on this matter, please list that information.

Name: ______________________________

Address: ______________________________

Phone: ______________ Specialty: ______________

5. Major Life Activities

Please check the major life activities you believe to be limited by your medical condition(s):

☐ Walking ☐ Caring for Oneself ☐ Breathing ☐ Seeing ☐ Working
☐ Talking ☐ Hearing ☐ Learning ☐ Performing ☐ Manual Task ☐ Other

Please describe how the above activities are limited:

6. Is your medical condition temporary? ☐ Yes ☐ No

If yes, please state the expected duration: ______________________________

7. Are you currently working? ☐ Yes ☐ No

If no, please specify the type of leave currently approved: ______________________________

8. Have you previously applied for a reasonable accommodation within FHDA?

☐ Yes ☐ No

If yes, please explain the status/circumstances: ______________________________

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> Please note: All medical/health information is maintained in a confidential file separate from your personnel file. Access to this information is restricted by law to authorized persons only.

I hereby certify that I believe I am a qualified individual with a disability. I believe I require an accommodation in order to perform the functions of my position. I understand that a detailed review of my disability status and this request for accommodation will be required and I agree to cooperate fully in this process. I further understand that if my request is granted, I am obligated to report any changes in my disability status, which may require a re-evaluation of this request. I also understand that this request for accommodation is pertinent to a particular position within my current department. Granting of this request does not signify approval of any future reasonable accommodation request for any other position within this department or any other department within Foothill-De Anza Community College District.

______________________________ ______________________________
Employee Signature Date

Accepted __________ Rejected __________ Effective Date __________

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Remarks

______________________________ ______________________________
Director of Benefits Signature Date

Return this Completed Form to: District Office of Human Resources. Address Above. Via email: MyBenefits@fhda.edu. For questions call (650) 949-6224.