



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

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.

Return this Completed Form to: District Office of Human Resources. Address above. For questions call (650) 949-6284.

**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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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 \_\_\_\_\_

\_\_\_\_\_  
Remarks

\_\_\_\_\_  
Director of Benefits Signature

\_\_\_\_\_  
Date

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