REQUEST FOR REASONABLE ACCOMMODATIONS

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: 29 U.S.C. Section 791; 29 C.F.R. Part 1614; see 20 C.F.R. part 1630.
PRINCIPAL PURPOSE: The information requested is for the purpose of gathering information related to the request for reasonable accommodations. Further, Executive Order 13164 mandates that Federal agencies have written procedures for proving reasonable accommodation and maintain records in order to monitor the effectiveness of the procedures.
ROUTINE USES: Solely used to gather information related to your request for reasonable accommodations.
DISCLOSURE: Completion of this form is voluntary. However, no accommodations may be given to a qualified individual without written information. Contents shall not be disclosed, discussed, or shared with individuals unless they have a direct need-to-know in performance of their official duties. Deliver this document directly to the intended recipient. **DO NOT** drop off, send to an unauthorized third-party or send via e-mail un-encrypt. Sending PII via regular e-mail is highly discouraged. Regular e-mail is sent "in the clear" and therefore is subject to interception by hackers. There are many other options for sending private, sensitive information or PII securely through e-mail. Please research these options and use them accordingly. This document contains personal or privileged information and should be treated as "For Official Use Only (FOUO)".

INSTRUCTIONS:

1. This form should be completed by the employee requesting reasonable accommodation.

2. Upon completion, please sign the form (digitally if available) and send to the Disability Program Manager (EEO Office) preferably via e-mail for assignment of a control number. Please select the "Submit via e-Mail" button at the bottom on any page and follow the prompts.

3. If you cannot send the form utilizing the "Submit via e-Mail" prompts, please save the form to your computer and e-mail, mail or hand carry the form utilizing any of the addresses or fax below (e-mail is the most preferred method of submission).

4. If a third party is completing this form on behalf of the employee or a management official is documenting an oral request, a copy of the completed form will be provided to the employee to confirm receipt of the request. These forms are used for record-keeping and reporting purposes only. They should be maintained separately from the employee's personnel file and are confidential documents.

5. The Disability Program Manager will send this form to the supervisor with a control number and FS Form 28b, Disposition of Reasonable Accommodations Request for processing.

Equal Employment Opportunity Office
1670 Craig Road
Fort Sill, Oklahoma 73503

usarmy.sill.imcom-central.mbx.usage-eeo@mail.mil
Telephone: (580) 442-4024
Fax: (580) 442-7205

* EEO USE ONLY* DPM LOG NUMBER:	LOG DATE:	SIGNATURE:

SECTION I - EMPLOYEE

a. TITLE:	b. NAME: FIRST:	MI:	LAST:	c. DATE:
d. GRADE:	e. SERIES:	f. e-MAIL:		
g. PHONE:	h. AGENCY/DIRECTORATE:			
h. SUPERVISOR'S NAME:		i. SUPERVISOR'S PHONE:		
j. SUPERVISOR'S e-MAIL:				

k. **NAME OF THE PERSON WHO INITIALLY RECEIVED THE REQUEST:** _____

RELATIONSHIP: *(Check all that is applicable)* ☐ IMMEDIATE SUPERVISOR ☐ EEO SPECIALIST ☐ DISABILITY PROGRAM MANAGER ☐ ANOTHER SUPERVISOR IN THE CHAIN OF COMMAND ☐ REASONABLE ACCOMMODATION COORDINATOR ☐ HR SPECIALIST ☐ OTHER:

l. **BRIEFLY DESCRIBE THE MEDICAL CONDITION REQUIRING ACCOMMODATION(S):**

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SECTION I - EMPLOYEE (CONTINUES)

m. **DESCRIBE SPECIFICALLY WHAT ACCOMMODATION(S) YOU THINK COULD BE MADE SO THAT YOU COULD PERFORM THE ESSENTIAL DUTIES OF THE POSITION. YOU MUST BE ABLE TO PERFORM ALL OF THE CRITICAL ELEMENTS OUTLINED IN YOUR PERFORMANCE APPRAISAL PLAN OR IN THE VACANCY ANNOUNCEMENT, EITHER WITH OR WITHOUT ACCOMMODATION.**

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SECTION I - EMPLOYEE (CONTINUES)

n. PLEASE CHECK ANY OF THE CATEGORIES BELOW THAT APPLY TO YOUR REQUEST:

☐ ALTERNATE WORK SCHEDULE ☐ ASSISTIVE DEVICES (NON-CLIENT ASSISTANCE PROGRAM (CAP) ☐ PARKING

☐ CAP REQUEST (COMPUTER OR ELECTRONIC OFFICE EQUIPMENT ☐ CAP REQUEST (COMPUTER SOFTWARE) ☐ SCOOTERS

☐ FURNITURE ☐ MATERIALS IN ALTERNATIVE FORMATS ☐ RE-CONFIGURED WORK SPACE ☐ TELEWORK

☐ REMOVAL OF AN ARCHITECHURAL BARRIER ☐ SIGN LANGUAGE INTERPRETER OR CAPTIONING REQUEST

☐ OTHER: _____

o. REASONABLE ACCOMMODATION(S) NEEDED FOR: *(Check all that is applicable)*

☐ PERFORMING JOB FUNCTIONS ☐ ACCESSING THE WORK ENVIRONMENT ☐ APPLICANT

☐ ACCESSING A BENEFIT OR PRIVILEGE OF EMPLOYMENT: (*e.g., ATTENDING A TRAINING PROGRAM OR SOCIAL EVENT*)

p. HOW LONG DO YOU BELIEVE YOU WOULD NEED THE REQUIRED ACCOMMODATIONS?

q. EXPLAIN ANY TIME SENSITIVE ISSUES RELATED TO THIS REQUEST:

IF DISABLILITY AND/OR NEED FOR REASONABLE ACCOMMODATION IS NOT OBVIOUS OR ALREADY ON FILE WITH THE AGENCY, THE AGENCY HAS A RIGHT TO REQUEST MEDICAL DOCUMENTATION TO SUBSTANTIATE THE DISABILITY AND THE REQUESTED ACCOMMODATION.* ***IF YOU HAVE BEEN ASKED TO PROVIDE ANY MEDICAL INFORMATION, THE INFORMATION SHOULD BE ATTACHED TO AND SUBMITTED WITH THIS FORM, UNLESS IT HAS ALREADY BEEN PROVIDED.**

SECTION II - CERTIFICATION AND CONSENT BY EMPLOYEE

I HEREBY CERTIFY THAT ALL STATEMENTS MADE ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY GIVE PERMISSION FOR THE RELEASE OF INFORMATION ABOUT MY SERVICE AND MEDICAL CONDITION(S) TO AGENCY OFFICIALS WITH A NEED TO KNOW. IF A DEPARTMENT OF DEFENSE FORM 2870, AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION, IS COMPLETED BY ME, I GIVE CONSENT TO RELEASE THE INFORMATION ON THE FORM FOR THE PURPOSE OF THIS REQUEST FOR REASONABLE ACCOMMODATIONS.

PLEASE FILL OUT DATE AND DAYTIME PHONE NUMBER BEFORE SIGNING THIS DOCUMENT!

_____	_____	_____
EMPLOYEE'S SIGNATURE	**DATE**	**DAYTIME PHONE NUMBER**