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| Send or fax to the Department of Personnel/Human Resources | Wayne County Department of Personnel/Human Resources REQUEST FOR ACCOMMODATION EMPLOYEE REQUEST AND RELEASE FORM | 500 Griswold 9th Floor Detroit, MI 48226 Fax: (313) 967-1228 |
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| EMPLOYEE REQUESTING ACCOMMODATION: Name (please print): | Employee ID #: |
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| Current Department: | Telephone #: Email Address: |
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- GENERAL INFORMATION -

Qualified individuals with a disability who are applicants for County employment or are currently employed by the County are covered by the provisions of the Michigan Persons with Disabilities Civil Rights Act and the Americans with Disabilities Act. Under these laws, a qualified individual with a disability is an individual with a Disability who, with or without reasonable accommodation(s), can perform the essential functions of the employment position that such individual holds or desires.

Under Section 37.1210 of the Michigan Persons with Disabilities Civil Rights Act the employer must be notified of the need for an accommodation within 182 days of becoming aware of the need for accommodation.

These laws require that an employer provide reasonable accommodations for qualified individuals with a disability in the performance of their job duties.

A reasonable accommodation is an employer's obligation to consider changes in its ordinary work rules, facilities, terms, and conditions that is in compliance with the American with Disabilities Act that enable a qualified individual with a disability to work. An employer has an obligation to make reasonable accommodations for qualified individuals with a disability unless it can show that the accommodation would cause an undue hardship on the operation of its business.

I certify that the information provided in this document is true and understand and consent to the submission of medical information regarding my request for an accommodation to my employer, or my employer's insurer. I understand that any false statements made by me may result in the denial of my Accommodation request.

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| Signature of employee or applicant: | Date: |
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*** DEPARTMENT OF PERSONNEL/HUMAN RESOURCES ***

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| <input type="checkbox"/> Approved | <input type="checkbox"/> Approved as Modified | <input type="checkbox"/> Denied |
| Comments: _____ _____ | | |
| Authorizing Signature: | Date: | |

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| <p>Submit along with Employee Request Form</p> | <p style="text-align: center;">Wayne County Department of Personnel/Human Resources REQUEST FOR ACCOMMODATION CERTIFICATION OF HEALTH CARE PROVIDER</p> | <p>500 Griswold 9th Floor Detroit, MI 48226 Fax: (313) 967-1228</p> |
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To be completed by Physician (Attach additional documentation if necessary)

BASED ON THE ATTACHED DESCRIPTION OF THE ESSENTIAL DUTIES AND YOUR PHYSICAL EVALUATION OF THIS PERSON:

Can this person perform all of the essential job functions?

Yes No

If **NO**, what job functions cannot be performed?

Can those job functions be performed with an accommodation?

Yes No

If **YES**, what accommodation is recommended for the performance of the duties?

I certify that the information provided in this document is true to the best of my knowledge and represents an accurate representation of the answers, opinions, and evaluations of the attending physician.

Name of Physician: _____ **Date:** _____

Signature of Physician: _____

Name of Practice and Address: _____

Signature of Person completing paperwork, if other than the attending physician. _____ **Date:** _____