

St. Clair County Community Mental Health
ADA Reasonable Accommodation Request Form

Date: _____

Employee Name: _____

Phone: _____

Email: _____

Job Title: _____

Department: _____

Supervisor Name: _____

1. Reason for Request

Describe the condition or limitation for which you are requesting accommodation. *(You are not required to disclose your diagnosis or medical details unless the limitation or need is not obvious.)*

2. Accommodation Requested

Describe the accommodation(s) you believe may help you perform the essential functions of your job. Please be as specific as possible (e.g., schedule adjustment, equipment, workspace modification, interpreter, etc.).

3. Alternative Suggestions (Optional)

If you are unsure what accommodation may be needed, are there any options you believe we should consider?

4. Health Care Provider Contact Information (Required only if medical documentation is needed)

If requested, please provide the name and contact information of your treating provider so that we may seek verification and/or recommendations:

Name: _____

Facility: _____

Phone: _____

Fax: _____

5. Documentation

You may attach any relevant documentation that supports your request, such as a note from a provider or recommended accommodation. Do not submit detailed medical records.

6. Authorization

By signing below, I affirm that the information I provided is accurate to the best of my knowledge. I authorize SCCCMH to communicate with my healthcare provider (if needed) to obtain limited information regarding my functional limitations and potential accommodations. I also understand that any information shared will be kept confidential and used only to evaluate this request.

Employee Signature: _____

Date: _____