Department of Corrections
WASHINGTON STATE

REQUEST FOR ACCOMMODATION

I am requesting consideration for a reasonable accommodation from the Department of Corrections to allow me to perform the essential functions of my position.

Name: _____ Classification/position: _____

Location: _____ Supervisor: _____

Specific limitations/restrictions: _____

_____

_____

Proposed accommodation: _____

_____

_____

Anticipated duration: _____

Health care provider: _____ Phone number: _____

Address: _____

I understand that I must cooperate with the Department of Corrections, which includes providing appropriate medical information, to determine what reasonable accommodation, if any, will be made.

If required by the Department of Corrections, I agree to release my medical information to the Appointing Authority/designee for the consideration of my request and have signed DOC 03-398 Authorization to Release Medical Information solely for that purpose. This release includes the ability to discuss my condition and necessary accommodations with my health care provider listed above.

I understand that any medical information provided will become part of my Employee Occupational Health Record and receive the same legal protections regarding disclosure as my other occupational health records.

I have received DOC 840.100 Disability Accommodation and Separation and understand that the Department of Corrections will make the final determination regarding reasonable accommodation.

_____ _____

Signature Date

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Distribution: **ORIGINAL** - Employee Occupational Health Record **COPY** - Health Care Provider