Applicant Reasonable Accommodation Request Form

Return Request to Human Resources

Name: _____ Date: _____

Position applying for: _____

E-mail Address:_____ Phone: (___) _____

Home Address: _____ City and Zip Code: _____

General: *The Mt. San Antonio Community College District is commited to providing the most appropriate accommodations for our employees and applicants for employment based on state and federal guidelines. The Applicant and Human Resources will engage in the interactive process in order to provide an appropriate accommondation.*

You are encouraged to contact Human Resources to discuss your questions regarding accommodations. Your request will be given thorough consideration. The Human Resources Representative may discuss alternatives with you and/or contact you for additional information before a decision is reached.

Please complete Items 1-6 and return this form to Human Resources prior to the listed initial screening date.

1. Reasonable Accommodation Request: (check all that apply):
   - ☐ I have a protected disability.
   - ☐ I have a record of having a protected disability.
   - ☐ I am regarded as having a protected disability.
   - ☐ I have a relationship/association with an individual who has a protected disability (and therefore am protected from discrimination due to that relationship/association).

2. I am requesting an accommodation to complete the employment application/testing process.
   - ☐ Yes
   - ☐ No

3. What type of accommodation(s) do you need?
   - ☐ Assistive device or equipment
   - ☐ Assistance applying for position
   - ☐ Testing flexibility
   - ☐ Other (Please describe) _____

     _____

     This is not an all inclusive list of possible accommodations.

4. Please explain how you believe this accommodation will enable you to apply for an open position.

_____
_____
_____
_____
_____
_____
_____
_____

5. Please provide us with the name of your health care provider(s) who can assist in this process.
Name:_____Medical Speciality: _____
Address:_____City: _____State:____Zip Code:_____
Phone Number: (___)_____

6. Signed Release of Medical Information Authorization Attached: _____Yes _____No

PLEASE BE PREPARED TO PROVIDE DOCUMENTATION OF YOUR PROTECTED STATUS

Please attach medical documentation on official letterhead explaining the functional limitation(s) your disability creates upon your ability to complete the application/testing process; and/or, ability to access our facilities.

Signature: _____ Date: _____

For HR Use Only

_____ Additional Medical Documentation Required: ☐Yes ☐No
Date Received in HR

_____
Accommodation Requested

Accommodation Approved: ☐Yes ☐No Date Applicant Notified: _____

_____
HR Technician

_____
Human Resources Representative