COUNTY OF SACRAMENTO

REQUEST for REASONABLE ACCOMMODATION in EMPLOYMENT EXAMINATION PROCESS

Please return this form by the final filing date to:
Disability Compliance Office, 700 H Street, Rm. 5720 Sacramento, CA 95814
Phone: (916) 874-7642 Fax (916) 874-7132 TTY/TDD (916) 874-7467

Applicant Name _____ Phone #_____

Exam Title _____ Final Filing Date _____

Type of Exam: ☐ Written ☐ Oral ☐ Performance ☐ Other _____

Definition of Disability under the California Fair Employment and Housing Act (FEHA): A physical or mental impairment that affects one or more of the basic bodily systems AND the condition must limit ability to participate in one or more major life activities.

1. Do you have a physical or mental impairment that would limit your ability to successfully complete an employment examination? **YES** ☐ **NO** ☐

2. Based on your understanding of the exam process, which aspect of the exam are you unable to accomplish without an accommodation because of your impairment/medical condition?

_____

_____

3. Based on your understanding of the exam process, what reasonable accommodation(s) could be provided that would enable you to complete this process? Be as specific as possible.

_____

_____

AUTHORIZATION & RELEASE:

As part of my request for reasonable accommodation, I authorize my health care provider to disclose to Sacramento County information relative to the physical/mental impairment addressed on this request form, and any related medical restrictions/limitations. I understand that this document will be kept in a confidential medical file, separate from my personnel file. I further authorize the County to disclose relevant medical restrictions/limitations as necessary to provide effective reasonable accommodation.

I understand that failure to submit this request and authorization by the FINAL FILING DATE may result in the County being unable to provide the requested accommodation.

Applicant Signature _____ **Date** _____

APPLICANT: Unless you have submitted medical verification to Sacramento County within the past 3 years, you must have your doctor complete the portion below.

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This request for reasonable accommodation will enable my patient to complete the County employment examination process. I certify that this patient has the above physical or mental impairment that would limit their ability to successfully complete an employment examination.

Name of Physician (PLEASE PRINT)_____**Phone**_____

Physician Signature_____**Date**_____

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STAFF USE ONLY: Date Received_____ Accommodation to be Provided? **Y** / **N** (if NO attach explanation)

Date Applicant Notified _____Staff Name/Title_____