

WCPSS EMPLOYEE TEMPORARY ACCOMMODATION REQUEST FORM

NAME:

POSITION:

EMPLOYEE #:

WORK SITE:

HOME ADDRESS:

EMAIL:

PHONE #:
(w)
(c)
(h)

SUPERVISOR(s) & PHONE #:

What is the situation or condition that is prompting you to make an accommodation request?
(e.g. nature of impairment; chronic or temporary condition, etc.)

Please describe the conditions of your current employment

Permanent or Temporary?
Full or Part -Time?
Contract status, if any:
Hours/week, if applicable:
Employment start date:

Please list all of your responsibilities of your current employment

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Please describe the job responsibilities that would be affected by your accommodation request:

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What specific accommodation request(s) are you proposing?

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Please describe the anticipated length of the accommodation(s) requested.

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Name and signature (or electronic signature) of person filling out form:

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Date:

Medical certification, either a statement from a licensed health care provider or another applicable form, **MUST** be included for your request to be considered and needs to include, at the minimum, the following information:

- The specific accommodation(s) requested
- Statement of medical need for each of the accommodations requested
- Starting date for each of the accommodations requested
- Anticipated end date for each of the accommodations requested

Please submit the completed form and medical certification statement to:

Jeff Koweek, Director of Employee Entitlements,
WCPSS Human Resources - Employee Relations
Crossroads I, 5625 Dillard Drive,
Cary, NC 27518
Fax: 854-1689 or jkoweek@wcpss.net

Human Resources Section Only

Result of Accommodation Request:

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Signature and date:

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Revised 3/16/11