LONG BEACH COMMUNITY COLLEGE DISTRICT

REASONABLE ACCOMMODATION REQUEST

Please complete this form and submit along with the Physician's Statement to the Office of Human Resources

Associate Vice President, Human Resources		Director, Human Resources	
Faculty	Academic Administrator	Classified	Classified Management

Name ____ Telephone: (______) ____________________
(Person requesting accommodation)

Address ____
Street City State Zip

1. Please check one of the following:

   I am requesting accommodation that will allow me to participate in a District offered program, activity or service.
   Activity name:____

   I am applying for employment. The accommodation requested will allow me to participate in the examination for
   (position title): ____

   I am currently employed by LBCCD and request a reasonable accommodation.
   ____
   Job Title Site Supervisor

2. Identify your specific problematic job tasks: ____
____

3. The accommodation I am requesting is described below. (Describe the type of accommodation, and possible solution; if it is a purchasable item list model, number, cost, where it can be obtained, etc., suggestions for work site or examination site modifications or specific job duties which may be restructured or shared to facilitate employment, participate in selection process or utilize a program, activity or service.) Please attach additional pages as necessary.

____
____
____
____
____
____

4. Describe how this accommodation will assist you. If additional information is necessary, please provide an attachment.__________
____
____

REQUESTOR/EMPLOYEE CERTIFICATION

I certify that I have a disability or medical condition that requires reasonable accommodation, which will be met by acquiring the equipment, services, or work adjustments described above.

Signature: ____ Date: ______________________

LONG BEACH COMMUNITY COLLEGE DISTRICT

REASONABLE ACCOMMODATION REQUEST

Physician's Statement

Instructions: The below-named individual is making a formal request for a Reasonable Accommodation as provided under the Americans with Disabilities Act. Please complete the Physician's Statement section and return the form to your patient.

If you should have any questions, please contact **LBCC Human Resources Department, Long Beach Community College District, 4901 E. Carson Street, Long Beach, CA 90808, (562) 938-4393**

To Be Completed By Employee

I hereby authorize ______________________________ to release medical information regarding my disability and request for accommodation to the Long Beach Community College District.

Signed: ______________________________ Date: ______________________________

Employee Name: ______________________________ Social Security No.: ______________________________
(last) (first) (m.i.)

Address/City/State/Zip: ______________________________

To Be Completed By Physician

Description of Disability:

Reasonable Accommodation Requested/Recommended:

Length of Time Accommodation is Requested:

Physician's Medical Opinion Regarding Employee's Existing Disability and Request for Reasonable Accommodation:

Doctor's Name: ______________________________ Phone: (__________) ______________________________

Firm Name & Address/City/State/Zip: ______________________________

____

Doctor's Signature: ______________________________ Date: ______________________________

LONG BEACH COMMUNITY COLLEGE DISTRICT

REASONABLE ACCOMMODATION REQUEST
Action Form

For Human Resources Use Only

Employee Name: ____ Social Security No.: ________________________________
(last) (first) (m.i.)

Position Title: ____ Number of Hours Per Day:

Location Name: ___________________________ Location Address: ____

Description of Disability:

Reasonable Accommodation Requested:

Length of Time Accommodation is Requested:

Comments: ____
____
____

All Documentation Supporting Decision to Approve Request Is On File

Circle One: **Approval / Denial**

Recommended By: ____ Date: ______________________________

Comments: ____
____
____

Approved By: ____ Date: ______________________________