

**REASONABLE ACCOMMODATION QUESTIONNAIRE**

The purpose of this questionnaire is to initiate and facilitate review of an employee's or applicant's request or reasonable accommodation of a mental or physical impairment that affects their ability to perform in the workplace. The requesting employee should complete Part 1. The supervisor to the position and/or the designated deciding official should complete Part 2. A written decision should be rendered to the employee within 30 calendar days. All persons involved in the reasonable accommodation process are required to keep all information concerning an employee's disability or medical condition strictly confidential.

**PART I (to be completed by employee or applicant)**

Name:		Phone Number:
Position:		Organization Code:
Accommodation required for:	<input type="checkbox"/>	Application process
	<input type="checkbox"/>	Performing job functions or accessing work environment
	<input type="checkbox"/>	Accessing a benefit or privilege of employment (e.g., attending training, social event)
Type of impairment:	<input type="checkbox"/>	Speech
	<input type="checkbox"/>	Visual
	<input type="checkbox"/>	Hearing
	<input type="checkbox"/>	Mobility
	<input type="checkbox"/>	Mental/Emotional
<input type="checkbox"/>	Other	

What is the impairment? (Please describe in sufficient detail, if not otherwise obvious)

Does the impairment substantially limit a major life activity? Describe the limitation(s).

Describe the impact of your limitations on the performance of the essential elements of your job or participation in the application process. Please describe in sufficient detail.

Describe the accommodation(s) requested and how you believe it may assist you to perform the essential elements of your position or to participate in the application process.

**MEDICAL DOCUMENTATION**

Provide appropriate medical documentation to substantiate the nature of the disability, the limitation(s) identified above, and the appropriateness of the requested accommodation(s).

**Privacy Act Statement:** The information you provide will be used primarily to facilitate the processing of your request for accommodation. Parties with a need to know will have access to this information as necessary and appropriate to make a determination. Failure to provide accurate and complete medical reports may make it difficult to properly process your request.

I certify that the statements and information provided are true and complete to the best of my knowledge. I hereby give permission to release any information contained in this request to authorized agency officials with a need to know.

**Employee/Applicant Signature Date**

**PART 2 (To be completed by Supervisor Designated Activity Deciding Official. A copy should be provided to the requestor to inform him/her of action on the request)**

<b>Date request received:</b>	
<b>Date accommodation approved or denied:</b>	
<b>Deciding Official's Name and Title:</b>	

**ACTION ON REASONABLE ACCOMMODATION REQUEST:**

<input type="checkbox"/>	Approved	Date Accommodation Provided
<input type="checkbox"/>	Denied	Request denied because: (may check more than one)
<input type="checkbox"/>	<input type="checkbox"/>	Accommodation ineffective
<input type="checkbox"/>	<input type="checkbox"/>	Accommodation would cause undue hardship
<input type="checkbox"/>	<input type="checkbox"/>	Medical documentation inadequate
<input type="checkbox"/>	<input type="checkbox"/>	Accommodation would require removal of an essential function
<input type="checkbox"/>	<input type="checkbox"/>	Accommodation would require lowering of performance or production standard
<input type="checkbox"/>	<input type="checkbox"/>	Other (please identify)

Provide detailed reason(s) for the denial of reasonable accommodation (must be specific, e.g., why the accommodation is ineffective or causes undue hardship).

If the individual proposed one type of reasonable accommodation which is being denied, but rejected an offer of a different type of reasonable accommodation, explain both the reasons for denial of the requested accommodation and why you believe the chosen accommodation would be effective

If an individual wishes to request reconsideration of this decision, s/he may take the following steps:

- Ask the deciding official to reconsider the denial and provide additional supporting information;
- Ask the NAVRESFOR CDEEOO to review the request and provide a recommendation to the activity head;
- File an EEO complaint pursuant to 29 C.F.R. § 1614, contact an EEO counselor **within 45 days from the date of this notice of denial of reasonable accommodation**; or
- File a written grievance per the provisions of the local Collective Bargaining Agreement, or Administrative grievance procedure as appropriate;
- Initiate an appeal to the Merit Systems Protection Board within 30 days of an appealable adverse action as defined in SC.F.R. § 1201.3; or
- Use the Alternate Dispute Resolution (ADP) process by contracting your EEO office or <http://www.adr.navv.mil/regionaladrcoordinators.asp>. Pursuing the ADP processes does not relieve the individual from adhering to the other time frames indicated above.