MERcer CoUnTy
reasonabLe aCCoMMoDatioN reQuest

(TOP PoRTioN TO BE FiLLEd OUT BY EMPLOYEE AND SuPERvisor)

Name:       Supervisor

Title:      Department     Phone #

TyPe oF ACCoMMoDatioN:

___ Work site       ___ Training       ___ Non-Structural       ___ Structural

Length of Accommodation       ___ Permanent       ___ Temporary – How long? ___ mos.

Is this accommodation related to an on-the-job-injury?       ___ Yes       ___ No

Name of Physician:  Address:  Phone#:  

Provide diagnosis and indicate any medical and/or physical limitations (attached medical
documents):

_________________________________________________________________

_________________________________________________________________

Describe type of accommodation requested (Include estimated cost if possible)

_________________________________________________________________

_________________________________________________________________

DoCTOR’S SIGNATURE:  DATE:

APPROvING AUTHORITY  APPROVED AS SUBMITTED  DISAPPROVED AS SUBMITTED  COMMENTS

DEPARTMENT DIRECTOR
RAIssA L. WaLKer
Personnel Director
THOMAS E. SHAW
Office for the Disabled
ANDREW MAIr
County Administrator

Rev.11/2008