



CITY OF SACRAMENTO
SERVICE RECIPIENT ACCOMMODATION
REQUEST FORM

REQUESTER:

NAME: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE/TDD: _____

This is a request for accommodation, which is needed because of my disability

1. I am applying for services provided by the **City of Sacramento**, Department of _____

2. A) The accommodation I am requesting will allow me to participate in the following activity and/or service:

B) I am I am not currently receiving services at the following location: _____

_____ and need an accommodation.

2. My specific functional limitation is: _____

3. The following accommodation will allow me to perform the essential requirements, and/or help me meet the eligibility requirements to seek equal participation in the services provided:

(Please describe the type of accommodation, how it will assist you, and details of where it can be obtained, it's cost, model number, etc.)

Requester's Signature

Date



CITY OF SACRAMENTO

SERVICE RECIPIENT ACCOMMODATION
MEDICAL INFORMATION AUTHORIZATION

Additional medical information is needed to provide the accommodation I have requested.

Therefore, I hereby authorize:

Physician's Name

Street Address

City/State/Zip

Phone

To release only that medical information pertinent to the accommodation needed as described on first page.

Applicant or Service Recipient

Date