



**CITY OF SACRAMENTO**  
**REASONABLE ACCOMMODATION**  
**REQUEST REVIEW FORM**

*This form is to be completed in full by the department and returned to the Affirmative Action Officer.*

**Requester's Name:** \_\_\_\_\_ **Date Request Received** \_\_\_\_\_

Currently employed by the City? Yes \_\_\_\_ No \_\_\_\_

Type of functional limitation: \_\_\_\_\_

Indicate the purpose for requesting accommodation: \_\_\_\_\_

\_\_\_\_\_

Describe the accommodation being requested \_\_\_\_\_

\_\_\_\_\_

Indicate the essential functions of the job or program/activity: \_\_\_\_\_

\_\_\_\_\_

Was a Request for Medical Information Form sent to the applicant's physician/medical provider/vocational/rehabilitation counselor?

No \_\_\_\_ Yes \_\_\_\_

The medical information provided the City was reviewed by (name): \_\_\_\_\_

\_\_\_\_\_

Can the person perform the essential functions of the job/program/activity when provided a reasonable accommodation?

No \_\_\_\_ Yes \_\_\_\_

List the accommodation options that overcome the limitations: \_\_\_\_\_

\_\_\_\_\_

What steps were taken to determine the effectiveness and feasibility of the proposed accommodations? \_\_\_\_\_

\_\_\_\_\_

**REQUEST FOR REASONABLE ACCOMMODATION:**

**GRANTED** \_\_\_\_\_ **DENIED** \_\_\_\_\_

If granted, indicate what accommodation will be provided. If denied, explain the rationale for this decision.: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Date of completion of Request Review:** \_\_\_\_\_

Staff person responding to Reasonable Accommodation Request:

**Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

(Dept. Head/Division Manager)