

Illinois AmeriCorps Disability Outreach Project
REASONABLE ACCOMMODATION MONITORING REPORT

Program: _____

Address: _____ State: _____ Zip: _____

Contact Name: _____

Telephone: (____) _____ Email: _____

Date accommodation approved: _____ Date of Report: _____

Specific Accommodation: _____

Date accommodation initiated (equipment ordered, worksite modification requested, etc):

Date accommodation completed: _____

Training Given: YES NO

Cost of accommodation: _____

Does the accommodation enable effective job functioning? How? _____

Is the member satisfied with accommodation? _____

Comments/explanation: _____

SIX MONTH FOLLOW-UP

Is the member still using the accommodation? YES NO

If no, why? _____

Is the member satisfied with the accommodation provided? YES NO

If no, why? _____

Is additional accommodation (s) needed? YES NO

If yes, what additional accommodations are recommended, why? _____

Name (Program Director)

Signature

Date

*Complete and forward to the Serve Illinois Commission
535 W. Jefferson, 3rd Floor, Springfield, IL 62702.*