COOK COUNTY SHERIFF'S OFFICE
AMERICANS WITH DISABILITIES ACT (ADA) REASONABLE ACCOMMODATION REQUEST FORM

TO BE COMPLETED BY EMPLOYEE

In accordance with the Americans with Disabilities Act (ADA), the Cook County Sheriff's Office shall provide a Reasonable Accommodation to Qualified individuals with disabilities to enable them to perform the Essential Functions of their positions. Any employee with a disability covered under ADA may request Reasonable Accommodation(s).

EMPLOYEE NAME (Last, First, M.I.)	JDE NUMBER:	DATE OF REQUEST:
DEPARTMENT:	SHIFT:	LOCATION:

REASON FOR ACCOMODATION(S)

What, if any, job function(s) are you having a difficulty performing?

Please describe any limitations resulting from your condition that interfere with your ability to perform the functions of your job:

Please describe the accommodation(s) you believe are needed to enable you to perform the essential functions of your job?

EMPLOYEE/APPLICANT WILL BE REQUIRED TO PROVIDE APPLICABLE MEDICAL DOCUMENTATION

I give the Cook County Sheriff's Office permission to explore Reasonable Accommodations under the Americans with Disabilities Act, and all applicable State and Federal laws. I understand that all information obtained during this process will be maintained and used in accordance with the ADA, including its confidentiality requirements.

EMPLOYEE'S SIGNATURE:	DATE:
DEPARTMENT/UNIT HEAD:	SIGNATURE:	DATE:

(FCN-88)(OCT 13)

RETURN TO:
Cook County Sheriff's Office
Personnel
Richard J. Daley Center – Suite 702
50 W. Washington
Chicago, Illinois 60602

TO BE COMPLETED BY PERSONNEL	
DATE PERSONNEL RECEIVED REQUEST:	DATE PERSONNEL MET WITH EMPLOYEE:

Essential Job Duties:

_____

_____

_____

_____

Requested Accommodation(s):

_____

_____

_____

_____

Action(s) Taken:

_____

_____

_____

_____

Was the employee advised of other available options? ☐ YES ☐ NO   If YES, what date: _____

_____

_____

ACCOMMODATION REQUEST:

☐ **APPROVED**

☐ **DENIED** *(Check all that apply):*

    ☐ **Accommodation would pose a direct threat to the requesting employee, or the health or safety of others.**

    ☐ **Accommodation would cause Undue Hardship on employer.**

    ☐ **Accommodation was rejected by employee.**

    ☐ **Requestor/Employee does not meet requirements per ADA.**

    ☐ **Other:** *(Please Identify)* _____

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_____

REVIEWING PERSONNEL STAFF:	SIGNATURE:	DATE:
DATE EMPLOYEE INFORMED OF ACTION:	METHOD OF NOTIFICATION:	