Accomodation Request
For Persons With Disabilities

U.S. Department of Housing and Urban Development
Office of Fair Housing and Equal Opportunity

Administrative Instructions

Before completing this form, read the reverse.
Entries: *May be either handwritten or typewritten.*
*Forms **Supply:** Use local office copier for initial supply & providing completed copies*
Copies Retained By: *(1) Office of Administration; (2) Disability Program Manager or EAP Staff; (3) Originating Office; (4) Employee.*

Requester

Others, such as Immediate Supervisor, Employee Assistance Staff, Disability Program Manager, Selective Placement Coordinator may help employee complete this section.

I request the following accomodation(s) to support the performance of my work:

My medical limitation/condition is (if necessary, medical documents are attached):

Name, Signature,Social Security Number, organization code, & Room Number :

Date.

Requester Comments

May be completed if form is initiated by others. Otherwise, entry not required

Immediate Supervisor

Date Received: Disapproved ☐ Approved ☐

Name, signature, date:

Comments (entry required if disapproval is recommended).

Oversight

Employee Assistance Staff, Disability Program Manager, Selective Placement Coordinator etc.

Date Received: Disapproved ☐ Approved ☐

Name, signature, date:

Comments (entry required if disapproval is recommended or if medical documentation is inadequate):

Approval

Primary Organization Head

Date Received: Disapproved ☐ Approved w/changes ☐ Approved ☐

Name, signature, date:

Comments (entry required if approved with changes, or it disapproved):

Funds Availability

Date Received: Not Available ☐ Available ☐

Name, signature, date:

Comments (entry required if funds are not presently available):

Privacy Act Statement

The Department of Housing and Urban Development (HUD), is authorized to collect this information under Section 501 of the Rehabilitation Act, as amend. The information provided by you will be used primarily to facilitate the processing of your request. Additional uses of the information may be to disclose information to: appropriate Federal, State or Local agencies when relevant to civil, criminal or regulatory investigations or prosecutions, when necessary to adjudicate a claim for benefits or to comply with a law governing the reporting of communicable diseases to Federal agencies in connection with a decision in hiring, retention or the granting of a security clearance; and to Federal agency, court or a party in litigation when HUD is a parity to the proceedings or is serve with a subpoena. Furnishing of the information is voluntary, failure to fully complete this form amy make it impossible for the Department to process the request.

Notice To The Employee With A Disability

If your accommodation request is denied, you have a right to file either an Equal Employment Discrimination Complaint or a Grievance under, the negotiated Union/Management Agreement procedures.

Completion Instructions

Requestor Section and Requestor Comment Section - to be completed by the employee or on behalf of the employee. Describe the medical condition/limitation and state the reason the accommodation is needed. Identify suggested accommodation or state if an appropriate accommodation is not known. Provide alternative accommodation(s) where possible. Explain what medical documentation is provided (attached) to support the request. If none is considered necessary, so indicate. Include in the Requestor Comment Section, any additional recommendation or comments. This section should also be completed when the form in initiated on behalf of the employee.

Requestor's signature and date - Self-explanatory. If the employee is unable to sign (e.g., in the hospital, etc.) or if initiated on behalf of the employee, the immediate supervisor, Employee Assistance Program (EAP) staff, Disability Program Manager/Selective Placement Coordinator will sign for the employee.

Immediate Supervisor Section - to be completed by the immediate supervisor. Indicate date request received; recommended action; justification for recommendation; and signature and date. Int eh event that the recommended action is disapproval, the comments portion should address one of the following:

Employee does not have a disability.
Employee had a disability but no accommodation is needed
The requested accommodation would impose an undue hardship on the agency.
There is a more appropriate accommodation available.

Oversight Section - to be completed by the EAP Staff, Disability Program Manager or Selective Placement Coordinator.Indicate date request received; recommended action; justification for recommendation; adequacy of medical documentation; and signature and date. In the event that the recommended action is disapproval, the justification should address one of the above conditions.

Approval Section - to be completed by the Primary Organization Head Indicate date request received; final action/decision; justification for decision; if action is approval, identify selected reasonable accommodation; signature and date. In the event that the final action is disapproval, the justification should address one of the above conditions identified under the Immediate Supervisor Section.

Funds Availability Section - to be completed by the Office of Administration.

Form Distribution

Copies of this form should be retained, after completion, by the following:

Originating office's Administrative Office (original)
Employee
Disability Program Manger/Selective Placement Coordinator or EAP Staff
Office of Administration (Funds Availability Approval Office)
(attach additional pages, if necessary)