

REQUEST FOR REASONABLE ACCOMMODATION

For use of this form, see AR 690-12, Appendix C Procedures for providing reasonable accommodation for individuals with disabilities, Dated 12 December 2019; the proponent agency for assistance is USAG-FLKS EEO

PRIVACY ACT STATEMENT

The information you provide is covered by the Privacy Act of 1974, Title 5, U.S.C. 552a.

AUTHORITY: Collection of this information is authorized by Sections 501 and 505 of the Rehabilitation Act of 1973, as amended 29 U.S.C. 794.

PRINCIPAL PURPOSE: Used for processing requests for reasonable accommodation by Department of the Army civilian employees and applicants for employment.

ROUTINE USES: Information will be used for support documentation and for review by appropriate agency personnel for requests for reasonable accommodation as defined in AR 690-12, Appendix C Procedures for providing reasonable accommodation for individuals with disabilities.

DISCLOSURE: Voluntary, however, failure to complete all appropriate portions of the form may lead to a delay in processing and / or denial of requests for reasonable accommodation on the basis of inadequate data.

FOR EMPLOYEE, APPLICANT AND MANAGEMENT'S USE IN PROCESSING AN REASONABLE ACCOMMODATION REQUEST.

1. DATE RECEIVED (MMDDYYYY)	2. REQUESTER'S NAME (Last, First MI) EMPLOYEE APPLICANT (NEW HIRE)	3. TELEPHONE NUMBER
4. POSITION / TITLE	5. REQUESTOR'S EMAIL	6. ORGANIZATION (IF APPLICABLE)

7. BRIEFLY DESCRIBE CIRCUMSTANCE(S) FOR REQUESTING REASONABLE ACCOMMODATION	MEDICAL	RELIGIOUS
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8. DESCRIBE SPECIFICALLY WHAT ACCOMMODATION(S) YOU ARE REQUESTING AND THINK COULD BE MADE SO THAT YOU COULD PERFORM THE ESSENTIAL DUTIES OF YOUR POSITION.
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9. RECEIVED BY (Last, First MI)	EMAIL	WORK TELEPHONE NUMBER
POSITION / TITLE/ ORGANIZATIONAL RELATIONSHIP TO REQUESTER	ORGANIZATION	SIGNATURE:

10. ARE YOU AUTHORIZED TO MAKE THE DECISION ON THIS REASONABLE ACCOMMODATION REQUEST (DECISION MAKER (IF "NO" PROVIDE THE DECISION MAKERS INFORMATION IN BLOCK 11))	YES	NO
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11. NAME OF DECISION MAKER (Last, First MI) OF REQUESTER AND EMAIL: (if different than Block 9)		
	EMAIL	
POSITION / TITLE	SIGNATURE	WORK TELEPHONE NUMBER

If a disability and/ or need for reasonable accommodation is not obvious or already on file with the Agency, the Agency **has a right to request medical information / clarification to substantiate the disability and the requested accommodation**. If you have been asked to provide any medical information, the information should be attached to the Medical Information Sheet (USAG-FLKS EEO Form RA-2.2) provided by Decision Maker during interactive process unless it has already been provided.

CERTIFICATION AND CONSENT BY REQUESTER

I hereby certify that all statements made above are true to the best of my knowledge and belief. I hereby give permission for the release of information about my service and medical condition(s) to agency officials with a need to know.

Requester's Signature _____ Date _____ Phone Number _____

If "Submit" does not work from Web-page save to computer then use "Submit" button

RA LOG NUMBER: _____ DATE: _____

Make sure to add your Supervisor on the CC line***

Note: This form should be completed by the requester making the reasonable accommodation request and provided to his/her/their supervisor. If a third party is completing the form on behalf of the requester or a management official is documenting an oral request, a copy of the completed form will be provided to the requester to confirm receipt of the request. Supervisors must provide a copy of this form to the EEO Disability Program Manager (DPM), who will assign a log number and return a copy of this form to the supervisor.