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**REQUEST FOR ACCOMMODATION**

Americans with Disabilities Act (ADA)  
Washington Law Against Discrimination (WLAD)

Employee Name \_\_\_\_\_ Date \_\_\_\_\_ Email \_\_\_\_\_

Building \_\_\_\_\_ Position \_\_\_\_\_ Supervisor \_\_\_\_\_

The Castle Rock School District is committed to providing a working environment that complies with laws and regulations prohibiting discrimination against people with disabilities. To the extent required by law, the Castle Rock School District engages in the interactive process to provide reasonable accommodation to all employees who are disabled, and for whom accommodation is medically necessary for them to perform the essential functions of their jobs.

This Request for Accommodation must be completed by the individual requesting the accommodation or a representative of the individual. Please attach additional pages if needed to further explain either the disability or the accommodation requested. The Castle Rock School District may seek additional information, opinions, or recommendations regarding requests for accommodation.

1. Describe your sensory, physical or mental limitation(s) and the expected duration of your limitation(s).
2. Describe how your sensory, physical or mental limitation(s) affect your ability to perform the essential functions of your job. (Identify job tasks you are unable to perform or would have difficulty performing without accommodation.) Also identify what, if any, job benefits you are having trouble accessing. Be as specific as possible.
3. Identify any modifications or accommodations you need to perform the essential functions of your job. Explain how you believe these modifications or accommodations will enable you to perform the essential functions of your job. Also, to the extent you know, provide information about the cost of the modifications or accommodations you are requesting.



4. What if any, accommodations(s) have previously been provided to assist you in performing your job?
  
  
  
  
  
  
  
  
  
  
5. Describe any accommodations you have previously requested that either were not provided or were not effective.
  
  
  
  
  
  
  
  
  
  
6. What other job related resources (e.g., vocational rehabilitation) have you used?
  
  
  
  
  
  
  
  
  
  
7. Is there any other information you believe would assist the Castle Rock School District in identifying and implementing appropriate reasonable accommodation(s)?
  
  
  
  
  
  
  
  
  
  
8. Please list doctors/physicians and other professionals who possess knowledge relative to the above stated disability and/or requested accommodations (include addresses and phone numbers):

Name	Address	Phone No.
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**By signing this form and submitting an Authorization to disclose Health Information for each provider listed above, I give permission for my Health Care Providers to provide the Castle Rock School District with any and all medical and other records or information associated with the aforementioned disability and request for accommodation that might be of assistance in evaluating this request and/or providing reasonable accommodation. I also acknowledge that I have been provided with a copy of the Castle Rock School District's Employment of Persons with Disabilities Policy (Policy No 5010)**

Signature of Employee\_\_\_\_\_ Date\_\_\_\_\_