



STATE OF ALASKA ADA REASONABLE ACCOMMODATION REQUEST

To be eligible for a reasonable accommodation under the Americans with Disabilities Act (ADA), you must (1) be qualified to perform the essential functions of your position and (2) have a qualifying disability that limits a major life activity. The ADA Amendments Act of 2008 emphasizes that the definition of disability should be construed in favor of broad coverage of individuals to the maximum extent permitted by the terms of the ADA and generally shall not require extensive analysis. See materials on the State's ADA website (www.alaska.gov/ada) or ask an ADA coordinator for more details.

This form aids employees and supervisors in the interactive process of reasonable accommodation. You may file a request directly with your supervisor, Division or Department ADA Coordinator, or departmental Human Resources Manager. You may also request assistance from the State ADA Coordinator or State EEO Program Manager in this process. All requests must be tracked with the Department and State ADA Coordinator's offices.

Employee Information

Name	Job Title	PCN
Department	Division	
Region/Section	Location	
Telephone	E mail	
Supervisor's Name	Telephone	Fax

1. In general indicate your disability and how it limits a major life function(s) *that relate to your job*.
2. If it bears on your request for reasonable accommodation, describe the effect of any mitigating measures you are using (medication, assistive technologies, mobility devices, etc.).

7. Do you need assistance to identify accommodations that will enable you to perform the essential functions of your job? If you do, explain what type of assistance you need.
8. Provide any information or suggestion you can on how the requested accommodation(s) can be provided. If known, include the names, addresses and telephone numbers of vendors and the model number and approximate cost of any equipment requested.

Employee Name (Please print)

Work Telephone

Signature

Date

**STATE OF ALASKA ADA REASONABLE ACCOMMODATION REQUEST
Departmental Review and Action**

Employee's Supervisor

1. Essential functions list attached: _____
2. Essential functions discussed with employee: Date _____
3. Requested modification(s) discussed with employee: Date _____
4. Recommendation and alternative(s) if needed: _____

Supervisor Name (Please print)

Work Telephone

Signature

Date

Approving Authority (as designated by agency policy)

Recommendation and alternative(s) if needed: _____

Division Director/Coordinator (Please print)

Work telephone

Signature

Date

Department ADA Coordinator

Recommendation and alternative(s) if needed: _____

Coordinator Name (Please print)

Work Telephone

Signature

Date

Commissioner (If requested accommodation denied)

Determination and alternative(s) offered: _____

Commissioner Name (Please print)

Signature

Date

CC: Division ADA Coordinator
Department ADA Coordinator
Department Human Resources Manager
State ADA Coordinator