



## MERCER COUNTY REASONABLE ACCOMMODATION REQUEST

(TOP PORTION TO BE FILLED OUT BY EMPLOYEE AND SUPERVISOR)

Name:		Supervisor
Title:	Department	Phone #

**TYPE OF ACCOMMODATION:**

Work site     
  Training     
  Non-Structural     
  Structural

Length of Accommodation  Permanent     Temporary – How long? \_\_\_\_\_ mos.

Is this accommodation related to an on-the-job-injury?     Yes       No

Name of Physician:	Address:	Phone#:

Provide diagnosis and indicate any medical and/or physical limitations (attached medical documents): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe type of accommodation requested (Include estimated cost if possible)

\_\_\_\_\_

\_\_\_\_\_

DOCTOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

APPROVING AUTHORITY	APPROVED AS SUBMITTED	DISAPPROVED AS SUBMITTED	COMMENTS
DEPARTMENT DIRECTOR			
RAISSA L. WALKER Personnel Director			
THOMAS E. SHAW Office for the Disabled			
ANDREW MAIR County Administrator			