

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
REASONABLE ACCOMMODATION REQUEST FORM
REQUEST FOR REASONABLE ACCOMMODATION UNDER THE AMERICANS WITH DISABILITIES ACT

Please complete either Box 1 if you are a DMHAS employee, Box 2 if you are an applicant for a DMHAS position.

Box 1		Date: _____
	Employee Name: _____	Position Title: _____
	Work Location: _____	Hours of Work: _____
	Immediate Supervisor's Name and Title: _____	
	Unit/Division Director's Name and Title: _____	

Box 2		Position Applied For: _____
	Applicant Name: _____	Date: _____ Position#: _____

EMPLOYEE/APPLICANT TO COMPLETE AND RETURN TO FACILITY EEO SPECIALIST

A. Please give a detailed description of your physical or mental impairment, including how it substantially limits one or more major life activities (such as seeing; hearing; breathing; speaking; smelling; walking; thinking/concentrating; learning; working; feeding; dressing; caring for one's self) (You may attach additional pages if needed)

B. Employees only: Please explain how the impairment limits your ability to perform essential job functions .

C. Employees/Applicants: Please describe the accommodation you are requesting.

EMPLOYEE/APPLICANT CONTACT INFORMATION: (PLEASE INDICATE YOUR PREFERENCE)

Mailing Address (work or home): _____	Phone # : _____
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If not approved employee/applicant has a right of appeal to the DMHAS EEO Director at: Connecticut Valley Hospital, 171 Bow Lane (Cottage 20) P.O. Box 351, Middletown, CT 06457. Telephone: 860-262-5863.