

**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.***

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

<b>Box 2</b>		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 # :

**If not approved employee/applicant has a right of appeal to the DMHAS EEO Director at: DMHAS Office of the Commissioner, 410 Capitol Avenue, 4th Floor, Hartford, CT 06106. Telephone: 860-262-5863.**