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 # :

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. Barbara.Viadella@ct.gov