Travis County

ADA ACCOMMODATION REQUEST

NAME:_____ EMPLOYEE ID#:_____

WORKSITE/DEPT:_____ DATE OF REQUEST_____

ADDRESS:_____ PHONE:_____

JOB TITLE: _____ MANAGER'S NAME:_____

1. Describe the nature of the concern:

_____

_____

2. Describe the basis for the determination of disability (if any):

_____

_____

3. Describe how the disability affects a major life function:

_____

_____

4. Describe the reasonable accommodations that you feel are necessary:

_____

_____

5. Additional Comments:

_____

Signature:_____Date:_____

(Please attach any relevant documentation and submit completed form to: Reid.Hoffman@traviscountytx.gov)

Questions? Call Reid Hoffman @ 512-854-9586