OMB Control No. 3045-0196
Expiration: XX/XX/XXXX
This form is available in written and accessible formats.

REQUEST FOR A MEDICAL REASONABLE ACCOMMODATION

By signing this form, you declare that the information you provide is true and correct to the best of your knowledge and ability. Any intentional misrepresentation to the Federal Government may result in legal consequences, including termination or removal from Federal Service.

To request a medical reasonable accommodation:

1. You must complete Part 1 of this form and submit it to the Disability Program Manager at reasonableaccommodation@cns.gov.
2. The Disability Program Manager will review your request and notify you if Part 2 must also be completed.
3. If you are notified, your medical provider must complete Part 2 of this form and you must submit it to the Disability Program Manager at reasonableaccommodation@cns.gov.
4. If more space is needed, please attach documents as necessary.

AmeriCorps is required to protect the confidentiality of any medical information you provide.

Privacy Act Statement

Authority:
We are authorized to collect the information on this form by Sections 501 and 505 of the Rehabilitation Act of 1973 (Pub. L. 93-112) (Rehab. Act), as amended, as these sections appear in volume 29 of the United States Code, beginning at section 791. Section 501 prohibits employment discrimination against individuals with disabilities in the Federal sector. Section 505 contains provisions governing remedies and attorney's fees under Section 501. Section 508 of the Rehabilitation Act requires that Federal agencies ensure comparable access for persons with disabilities whenever an agency uses electronic or information technology, unless such access would impose an undue burden on the agency.

Purpose:
This information is being collected and maintained to document your need for a reasonable accommodation and is required to establish that you have a covered disability, the functional limitations of your disability, and the need for reasonable accommodation. If you fail to fully complete the form or refuse to provide the requested documentation, your reasonable accommodation process could break down and your request may be denied.

Routine Uses:
The information requested on this form is intended to be used primarily for internal purposes. However, in certain circumstances it may be necessary to disclose this information externally. Examples include: to disclose information to: a Federal, state, or local agency to the extent necessary to comply with laws governing reporting of communicable disease or other laws concerning health and safety in the work environment; to adjudicative bodies (e.g., the Merit System Protection Board), arbitrators, and hearing examiners to the extent necessary to carry out their authorized duties regarding Federal employment; to contractors, grantees, or volunteers as necessary to perform their duties for the Federal Government; to other agencies, courts, and persons as necessary and relevant in the course of litigation, and as necessary and in accordance with requirements for law enforcement; or to a person authorized to act on your behalf. A complete list of the routine uses can be found in the system of records notice associated with this collection of information, CNCS-10-CEO-PHRI, Personal Health and Religious Information (86 FR 6458).

Paperwork Reduction Act Statement

This information is collected to determine whether you are entitled to an accommodation under law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB Control Number. The public reporting burden for both Part 1 and Part 2 of this form is estimated to average 3 hours per response, including the time for reviewing instructions, gathering and maintaining data, and completing and reviewing the form. Direct comments regarding burden estimates or any other aspect of this form to the AmeriCorps Information Collection Clearance Officer at PublicComments@cns.gov.

Reasonable Accommodation Tracking Number_____ (will be added after form is submitted)

Person Requesting Accommodation		Date of Request
Office / Program		**Work / Volunteer Location**
Position	**Supervisor**	**Phone Number and Email Address**

INFORMATION ABOUT YOUR REASONABLE ACCOMMODATION REQUEST

1. **What type of accommodation are you requesting?** Be as specific as possible – for example, adaptive equipment, readers, sign language interpretation, personal assistance in the workplace, modification of your job, etc.

For questions 2 and 3, you are not required to reveal your exact medical condition/diagnosis, but you must provide enough information to help us arrive at a decision:

2. **Why is the requested accommodation medically necessary?**
   (Note: if either: (a) your disability and the need for reasonable accommodation are obvious; or (b) you have already provided the agency with sufficient information to document the existence of the disability and functional limitations, you may indicate (a) or (b) in lieu of responding to this question)

3. **How will the requested accommodation (or an alternate accommodation) be effective and allow you to perform the essential functions of your position?**

4. **If the accommodation you're requesting is time sensitive, please explain:**

Requester's Signature
I declare to the best of my knowledge and ability that the foregoing is true and correct.

Print Name	Date

Part 2 – To be Completed by the Person Requesting Exemption's Medical Provider

Patient Name:

Medical Certification of Need for a Reasonable Accommodation

Dear Medical Provider:

The individual named above is seeking a reasonable accommodation for a medical condition. Please complete this form to assist AmeriCorps in its reasonable accommodation process. An accommodation is a logical adjustment made to a job and/or the work environment which enables a qualified employee with a disability to successfully perform the essential duties or functions of the position.

Please provide medical information to demonstrate that the individual has one or more physical or mental impairments that substantially limit(s) one or more major life activity (e.g., walking, speaking, breathing, hearing, seeing, thinking, sitting, standing, reaching, interacting with others, learning, performing manual tasks, caring for themself, concentrating, lifting, working, sleeping). ***You do not have to provide the exact diagnosis, but the information provided should indicate that the requested accommodation is based on a medical condition and will allow the requestor to perform the essential functions of their position. Attach additional pages if necessary.***

If you have questions about completing this form, please contact the Disability Program Manager at reasonableaccommodation@cns.gov.

1. What activity(ies) does the impairment limit?

2. To what extent does the impairment limit the individual's ability to perform the activity(ies)?

3. Why does the individual require reasonable accommodation or the particular accommodation requested?

4. How will the accommodation assist the individual to apply for a job, perform the essential functions of a job, or enjoy a benefit of the workplace?

5.a. Is this a temporary medical condition/circumstance?

b. If temporary, when is it expected to end?

Medical Provider Name/Title/Address/Telephone Number

Medical Provider Signature	**Date**