REQUEST FOR REASONABLE ACCOMMODATION
UNDER THE AMERICANS with DISABILITIES ACT (ADA)

Many accommodations are simple changes in procedures or one-on-one assistance to ensure that access is provided; curbside assistance, alternative format for communication, printing information in large font, etc. This form may be completed and returned directly to the Department providing the program or service so they may best serve you. The form may also be completed and returned to: St. Charles County Human Resources, ADA Coordinator, 201 N. Second, Room 519, St. Charles, MO 63301. For assistance in completing this form contact Human Resources, ADA Coordinator, at 636-949-7320, or humanresources@sccmo.org.

Please Print

NAME: ____________________________   DATE: __________________________
PHONE: (_____)_________________ ADDRESS: __________________________________________
CITY, STATE & ZIP CODE: __________________________________________________________

1. _____ EMPLOYEE _____ APPLICANT _____ CITIZEN
2. _____ Assistance with performing essential job functions, or _____ Assistance with testing and hiring procedures, or _____ Assistance with using or accessing services and programs provided by the County, or _____ Accessibility of facilities or buildings.

3. A. Title of Position: _________________________ (Applied for or Performing), or
B. Identify the Program or Service: _________________________________, or
C. Identify the Building or Facility: _____________________________________

4. Department with Position or Service: _________________________________________

5. Describe your disability and based on your disability the assistance needed for Question 2.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

   a. If you are requesting a very specific accommodation, how will that accommodation assist you?
   __________________________________________________________________________
   __________________________________________________________________________

   b. If you do not know what accommodation is needed do you have any suggestions as to what options we should explore? If yes, explain ________________________________________________________________
   __________________________________________________________________________

   c. Is your accommodation request time sensitive? If yes, explain _____________________________
   __________________________________________________________________________

   d. Have you had an accommodation in the past for your limitation? _____ YES _____ NO,
   If yes, what was it and how effective was it? ______________________________
   __________________________________________________________________________

6. Any additional information that you believe would be helpful for the County in processing this request for accommodation.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Signature: _________________________________________________________________________
EMPLOYEES ONLY:

7. What specific job function, if any, are you having difficulty performing?
   
   ____________________________________________________________
   
8. What specific employment benefit, if any, are you having difficulty accessing?
   
   ____________________________________________________________
   
9. What limitation is interfering with your ability to perform your job or access employment benefits?
   
   ____________________________________________________________
   
Employee Signature: ___________________________________________