Accommodation Request

20-1927
04-11

verizon

SECTION 1 – TO BE COMPLETED BY EMPLOYEE OR APPLICANT

INSTRUCTIONS:

- This form may be completed electronically or by using the paper form.
- Please provide **full** and **complete** responses to each question below and return this form to your supervisor.
- If you do not want your supervisor to see your responses:
  1. Answer that question on a separate paper
  2. Sign and date the separate sheet and place it in a sealed envelope
  3. Write "see attached" in the applicable box on the form below
  4. Give the sealed envelope and the form to your supervisor

EMPLOYEE / APPLICANT NAME	**VZID**
ORGANIZATION NAME AND LINE OF BUSINESS NAME	☐ **UNION NAME & LOCAL** ☐ **NON-UNION OR MANAGEMENT**
EMPLOYEE / APPLICANT WORK LOCATION / ADDRESS	**EMPLOYEE / APPLICANT PHONE NUMBER**

EMPLOYEE JOB TITLE or JOB TITLE APPLICANT IS APPLYING FOR:

CURRENT EMPLOYEES ONLY:

Specifically identify the functions of your job that you are either unable to perform or are substantially limited in performing.

CURRENT EMPLOYEES AND APPLICANTS:

Identify requested workplace accommodation (either in current job or during interview/testing process).

Describe how this accommodation will enable you to either:
(1) Perform the essential functions of your job or (2) Complete the interviewing/testing process:

CURRENT EMPLOYEES ONLY:

Indicate how long this accommodation will be required.

NOTE: If requested accommodation is for time off or a leave of absence, identify as specifically possible the amount of time off or the duration of the requested leave of absence.

☐ **The accommodation is required indefinitely.**
☐ **The accommodation is required for the following time period: to .**

EMPLOYEE or APPLICANT SIGNATURE (or preparer's signature if verbal) NOTE: Typed name will be accepted as signature.	**DATE**

IMPORTANT NOTES:

1. The Workplace Accommodations Team will contact you to request medical documentation of disability if required.
2. For questions or further instructions regarding the accommodation process, please contact the Workplace Accommodations Team on **1-877-635-1231** or workplaceaccommodationsteam@verizon.com

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SECTION 2 – TO BE COMPLETED BY SUPERVISOR OF CURRENT EMPLOYEE OR BY ASSESSMENT & SELECTION MANAGER IF FOR APPLICANT

INSTRUCTIONS:

1. Verify employee has completed and signed Section 1.
2. Complete and sign Section 2.
3. Submit form to Workplace Accommodations Team as noted below. Call **1-877-635-1231** with any questions.
   - Fax to **1-866-315-9615**, or
   - E-mail to workplaceaccommodationsteam@verizon.com
   - If employee provides information in a sealed envelope, mail sealed envelope and form to: Verizon Workplace Accommodations Team, 1 Verizon Way, Mail Code VC33W444, Basking Ridge, NJ 07920.

SUPERVISOR / ASSESSMENT & SELECTION MGR NAME	SUPERVISOR VZID

SUPERVISOR JOB TITLE

SUPERVISOR / ASSESSMENT & SELECTION MGR WORK LOCATION / ADDRESS	SUPERVISOR / ASSESSMENT & SELECTION MGR PHONE NUMBER

IDENTIFY THE EMPLOYEE'S ESSENTIAL JOB FUNCTIONS	IDENTIFY THE REASON FOR REFERRAL (e.g., Need for Medical Assessment, CBA issue, impact on co-workers, etc.)

PROVIDE OTHER SUGGESTED ACCOMMODATION(S), IF ANY, THAT WILL ENABLE THE EMPLOYEE OR APPLICANT TO PERFORM ESSENTIAL JOB FUNCTIONS
(Either during interview/testing process or in current job)

SUPERVISOR / ASSESSMENT & SELECTION MGR SIGNATURE NOTE: Typed name will be accepted as signature.	DATE

IMPORTANT NOTES:

1. The Workplace Accommodations Team will contact employee if medical documentation of disability is required.
2. **Distribution:**
   - Fax completed form to the Workplace Accommodations Team on **1-866-315-9615** or e-mail to workplaceaccommodationsteam@verizon.com
   - Provide copy of form to HR Business Partner
3. For questions or further instructions regarding the accommodation process, please contact the Workplace Accommodations Team on **1-877-635-1231** or workplaceaccommodationsteam@verizon.com

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SECTION 3 –TO BE COMPLETED BY WORKPLACE ACCOMMODATIONS TEAM

WORKPLACE ACCOMMODATIONS CONSULTANT NAME	DATE MEDICAL ASSESSMENT RECEIVED FROM MEDICAL REVIEWER (IF APPLICABLE)

WORK RESTRICTION(S) BASED ON MEDICAL ASSESSMENT (IF APPLICABLE)

COMMUNICATIONS / CONVERSATIONS WITH EMPLOYEE (INCLUDE DATE, DESCRIPTION, AND OUTCOME OF EACH CONTACT)

RECOMMENDED ACCOMMODATION(S) INCLUDING RATIONALE

ESTIMATED COST OF ACCOMMODATION	FINAL COST OF ACCOMMODATION

ACCOMMODATION(S) REVIEWED / APPROVED BY:	NAME:	DATE:
☐ SUPERVISOR / MANAGER		
☐ HR BUSINESS PARTNER		
☐ LEGAL		
☐ STAFFING		
☐ OTHER		

IMPLEMENTATION / INSTALLATION INFORMATION

ADA TECHNICAL TEAM COORDINATOR NAME	COORDINATOR TELEPHONE NUMBER	PROJECTED COMPLETION DATE	ACTUAL COMPLETION DATE

STATE RATIONALE FOR EMPLOYEE REQUESTS WHICH ARE NOT APPROVED

(Explain in detail, i.e., Requested accommodation would not enable employee to perform essential job functions; Alternate accommodations are less costly/more effective, etc.)

DATE EMPLOYEE/ APPLICANT NOTIFIED	EMPLOYEE NOTIFIED BY
ACCOMMODATIONS CONSULTANT SIGNATURE NOTE: Typed name will be accepted as signature.	**DATE**

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SECTION 4 – TO BE COMPLETED BY SUPERVISOR EVALUATION RESULTS (Evaluation to be conducted within 30 days of implementation)	
DATE:	
EFFICIENCY:	
EFFECTIVENESS:	
COMMENTS:	