

	West Central Region Local Policy	
	Subject: WDB Accommodation Request	Release Date:
	Reference:	Revision:

Please complete this form as part of your request for an accommodation. Submit this document directly to the WDB Executive Director, along with medical documentation to support your request (if applicable). If there is not enough space on this document, attach pages as needed. This request form can be completed for either a religious accommodation or disability related accommodation. Please complete the information for the correlating request. For questions, please contact the WDB Executive Director and refer to the Workforce Development Board of Western Missouri, Inc. (WDB) Policy located online at www.skillupmissouri.org.

Employee Information

Name	
Job Title	
Work Location	
Supervisor's Name	

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Disability Related Accommodation

1. Describe how your condition affects your ability to perform a major life activity. Which major life activity (s) is/are most significantly affected? Examples of major life activities include: seeing, hearing, breathing, walking, smelling, caring for yourself, thinking, or sitting. This list is not exhaustive.

2. Describe how your condition limits your ability to perform the essential functions of your job. Identify the essential functions affected and be specific about how the medical condition impairs your ability in each instance.

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3. Describe the accommodation you are requesting.

4. Is the need for this accommodation likely to be temporary or permanent? If temporary, how long do you estimate the need for this accommodation to exist?

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5. Explain how the accommodations you are requesting will enable you to perform the essential functions of your job. Be specific.

6. Will you be able to perform all of the essential functions of your job if you receive the requested accommodation? If not, describe the specific functions you will not be able to perform.

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7. Please provide as much information as possible about your requested accommodation, to include vendor or model number and approximate cost of any equipment requested. Do you need assistance to identify accommodations that will enable you to perform the essential functions of your job? If you do, please explain what type of assistance is needed.

8. Identify the names and addresses of physicians, therapists, psychologists, or other health care providers who have information or documentation concerning your disability and/or your need for an accommodation.

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I herby authorize the above listed health-care providers and any others who have treated me to release to the WDB all medical records concerning the disability disclosed on this form and provide any opinions to the WDB concerning my ability to perform job-related functions with or without a reasonable accommodation.

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that any misrepresentation may be cause for my termination.

Employee Name (please print)

Work Telephone

Signature

Date

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Religious Accommodation

1. Please specify the religious belief, practice, or observance that is the basis for your request for accommodation.

2. Please specify the work requirement that conflicts with the religious belief, practice, or observance describe above and explain the nature of the conflict.

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3. Please describe the specific accommodation (s) that you are requesting at this time, including an explanation of how the requested accommodation (s) will enable you to meet your religious obligations without impacting your ability to meet the required/essential functions of your job.

4. What are some other accommodation options that might address your needs?

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Additional Comments/Information (if any)

In some cases, the WDB will need to obtain documentation or other authority regarding your religious practice or belief. For example, the WDB may need to discuss the nature of your religious belief(s), practice (s), and accommodation with your religion’s spiritual leader (if applicable) or religious scholars.

_____ The WDB has permission to contact my religion’s spiritual leader or religious scholars.

_____ I certify the information that I have provided is true and accurate to the best of my knowledge. I understand that any misrepresentation may be cause for my termination.

Employee Name (please print)

Work Telephone

Signature

Date