State of Delaware
Department of Human Resources

Reasonable Accommodation Determination Form Americans with Disabilities Act (ADA)	
Policy #: To be assigned.	**Authority: Americans with Disabilities Act Amendments Act of 2008 (ADA)**
Effective Date: September 1, 2020	**Supersedes:**

PART 1:

Employee Name: _____ Job Title: _____

Agency/Division: _____ Date: _____

Email/Phone: _____

PART 2:

1. Date and how reasonable accommodation requested: _____

   _____

2. Type(s) of reasonable accommodation(s) requested (e.g., adaptive equipment, staff assistant, removal of architectural barrier): _____

   _____

3. List date(s) of Interactive Dialogue meeting(s): _____

   _____

4. If Reasonable Accommodation Procedures required an extension (longer than 15 business days), explain why: _____

   _____

5. Was medical information required to process this request? If yes, explain why. When was it requested? When was it received? How will selected/agreed upon reasonable accommodation assist employee in performing Essential Functions of job? _____

   _____

   _____

6. Type(s) of reasonable accommodation and date provided: _____

   _____

7. Time frame for follow up with employee: _____
8. Additional Comments: _____

   _____

PART 3:

Submitted by: _____ Date: _____

Email: _____ Phone: _____

☐ By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A party's electronic signature for purpose of the Uniform Electronic Transactions Act, 6 *Del. C.,* Ch. 12A, may be provided by checking a box as indicated, electronic initials or name, or email confirmation.