Idaho Military Division (IMD)
Reasonable Accommodation Request Form

PART A: COMPLETED BY REQUESTOR, then submit to the direct supervisor, the contact listed on the vacancy announcement, or other alternate representatives as in the IMD Reasonable Accommodation Standard Operating Procedure.

Name of Person Needing Accommodation:
Preferred Contact Email:
Personal Phone#: Work Phone#:
Date of Request: Position Title:
Status: ☐ IMD Title 32 Federal Technician ☐ IMD Title 5 Federal Technician
☐ IMD Federal Qualified Job Applicant (Announcement #)

NATURE OF THE QUALIFYING DISABILITY:

Identify the specific functions or employment benefit you/they are having difficulty completing.

Describe the barrier or limitation that is interfering with your/their ability to perform job functions or access an employment benefit.

Identify the anticipated duration and frequency of the needed accommodation.

One time (Date needed:)
Less than 2 weeks, ☐ Continuous or ☐ Intermittent (Freq.:)
More than 2 weeks, continuous block of time - days, weeks, or months (Freq.:)
More than 2 weeks, intermittent basis – periodic or occasional (Freq.:)

REQUESTED/SUGGESTED ACCOMMODATION:

Identify the specific accommodation are you requesting and explain how that accommodation will assist you/them.

List any suggestions for alternate accommodation options that may be considered if the requested accommodation is denied.

Have you/they previously received accommodations(s) in the past for this same limitation? (Identify what accommodations were granted.)

Is this accommodation request time sensitive?

☐ No
☐ Yes (Date/Time needed:)
☐ Accommodation is needed for a short notice un-forecasted mission requirement.
☐ Accommodation is needed due to an immediate health concern.
☐ Other:

Provide any additional information that might be useful in considering this request:

I understand that the Disability Program Manager may require sufficient medical documentation establishing the underlying disability or medical issue. I understand that while a specific change due to a medical condition my be requested, this request does not necessarily mean that the employer is required to provide that change.

Requestor's Signature	Requestor's Name	Date

APPENDIX A: IMD REASONABLE ACCOMODATION REQUEST FORM

PART B: COMPLETED BY SUPERVISOR/REPRESENTATIVE (Once completed submit to the DPM)

Date supervisor/representative became aware of the need for an accommodation (Date of request.)
Date supervisor/representative received this form.

Did you provide/discuss the following with the employee?

Yes No Notice of where to find the IMD RA SOP?

Yes No Notice on how to contract the DPM?

Yes No Notice that they may be required to provide the DPM with sufficient medical documentation establishing the underlying disability or medical issue?

Yes No Notice of a time expectation of a approved/disapproved RA? (Not later than 30-calendar days)

Provide any additional information that might be useful in considering this request:

For those accommodations lasting less than 2-weeks and/or have no cost to the IMD, approval may be granted immediately by the supervisor. Supervisor approvals must be in accordance with the guidelines specified under "Approval or Denial of Accommodation Request" in the IMD Reasonable Accommodation Standard Operating Procedure. Supervisors will communicate with the DPM prior to granting any accommodation.

The supervisor will implement any approved reasonable accommodation at the earliest possible moment, but within (30) thirty calendar days from the date of request. Failure to provide an accommodation in a prompt manner may result in a violation of the Rehabilitation Act 29 CFR § 1614.203(d)(3)(i)(O).

If the duration of the accommodation being considered will exceed 2-weeks in duration or result in cost to the IMD or is for a Personal Assistance Service (PAS), the supervisor must coordinate with the DPM office who will assign a tracking number.

Any requested accommodation for which a disapproval is contemplated must be first be coordinate with the DPM office who will assign a tracking number.

Supervisor/Representative's Signature | Supervisor/Representative's Name | Date

PART C: COMPLETED BY THE DISABILITY PROGRAM MANAGER

Date the DPM became aware of the need for an accommodation (Date of request.)
Date DPM received this form.
Tracking Number Assigned.

Provide any additional information that might be useful in considering this request:

DPM Representative's Signature | DPM Representative's Name | Date