



Applicant Self-Identification and Request for Accommodation Process Form
(Americans with Disabilities Act)

All individuals with a disability as defined under the Americans with Disabilities Act, as amended, during the application and/or selection process may request reasonable accommodations.

A person with a disability is an individual who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment; or is regarded as having such an impairment. A record of impairment is a history of a substantially limiting mental or physical impairment, which includes persons who have recovered or are not now substantially limited. A person is regarded as having an impairment where he or she has been subjected to an action prohibited by the Act because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.

It is the responsibility of the applicant with a documented disability to self-identify during the application, interview or selection process and make a request to Chesterfield County that an accommodation is needed. This confidential process is coordinated by the Department of Human Resources to help ensure that the rights of all parties are protected. Requests for a reasonable accommodation will be assessed and evaluated on a case-by-case basis.

The steps are as follows:

1. Job applicant completes the **Applicant Self-Identification and Request for Accommodation Form**.
2. The applicant takes the **Physician Certification Form** and the job posting and/or hiring process requirements to his/her physician. However, an applicant may already have appropriate supporting documentation of their disability and accommodation needs that can be provided to the Department of Human Resources (HR) in lieu of the Physician Certification Form.
3. Applicant forwards the **Applicant Self-Identification and Request for Accommodation Form**, along with the **Physician Certification Form** to HR.
4. HR contacts the applicant and hiring department to engage in the interactive process within 5 calendar days of receipt of the forms to review and evaluate the request.
5. HR will evaluate the request (taking into account the applicant needs and the hiring process) and may consult with the County Attorney. Once all documentation is received, HR will respond to the applicant within 15 calendar days.

**Chesterfield County
Department of Human Resources**

Applicant Self-Identification and Request for Accommodation Process Form*
(Americans with Disabilities Act)

This form must be completed when an applicant wishes to self-identify and make a request for accommodation due to a documented disability. This form must be submitted to the Department of Human Resources (HR).

HR will review the information to determine whether a reasonable accommodation is required for an applicant to participate in application, interview and/or selection process.

Applicant Name:	Applicant Phone Number:
Position Applied For:	Date of Scheduled Interview and/or Test:

Department:

1. Please describe which major life activity your impairment limits. (For example: caring for oneself, performing manual tasks, walking, seeing, hearing, sitting, speaking, breathing, learning, remembering, concentrating, major bodily functions, etc.) Attach additional pages if needed.

2. Describe how your condition limits your ability to participate in the job application, interview and/or selection process.

3. Describe in detail the accommodation(s) you are requesting.

4. Please add any additional information you feel may be relevant to your request:

Applicant Signature:	Date:
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*This form is to be kept confidential and does not become a part of the applicant's personnel file should the applicant be selected.

**Chesterfield County
Department of Human Resources**

**PHYSICIAN'S CERTIFICATION
FOR EMPLOYEE/APPLICANT ACCOMMODATION
(AMERICANS WITH DISABILITIES ACT)**

Human Resources has received notice from you indicating that you have a condition that requires an accommodation in the workplace. In order to process this request, additional information is needed from the treating physician. Please ask your physician to review your job description with you and complete this certification and return as soon as possible. This information must be received in order to evaluate your request.

Employee Name _____ **Position** _____

1. Describe the (a) nature, (b) severity, and (c) duration of the employee's/applicant's impairment.

2. Describe the life activity or activities the impairment limits (i.e. walking, breathing, seeing, sleeping, caring for self, major bodily functions, etc.)

3. Describe the extent to which the impairment limits the employee's ability to perform the "essential" functions of the job as described in the attached job description.

4. Describe the modification/accommodation that should be evaluated by the county to determine if reasonable and may assist the employee in performing the essential functions of the job.

5. Are there any alternative modifications/accommodations that may also be feasible (not listed in #4)?

Physician's Signature

Date

Physician's Printed Name

Address

Telephone Number