WISCONSIN LEGISLATURE
Reasonable Accommodation Request Form

Employee: Please complete this form to request work related reasonable accommodation(s). Save a copy for your personal records. ***Please be aware that the Legislative Human Resources Office (LHRO) may request additional information from you or your medical provider to evaluate your accommodation requests.***

Section I: Employee/Employee's Medical Provider

Name of Employee:	**Job Title:**
Legislative Office:	**Employee's Work Number:**
Please state the accommodation(s) you are requesting and medical need for the requested accommodation(s).	
Employee Signature:	**Date:**

EMPLOYEE'S MEDICAL PROVIDER: ***Please either provide the employee with a letter responding to the below questions or fill in the below questions on this form.***

What is the employee's medical need for the requested accommodation(s)?

Please state the accommodation(s) you are recommending for the employee.

Are there any time frames related to the requested accommodation(s) (e.g.., The employee will need the accommodation in place for 6 months.)? If so, please state those time frames.

Medical Provider Name, Address, and Phone Number**:**

Medical Provider Signature:	**Date:**

Section II: Supervisor

Supervisor: Please complete Section II. Please consult with the LHRO (608-316-9700) if you have any questions.

Supervisor Signature	**Approve** ☐	**Deny** ☐	**Date of Approval:**

Section III: LHRO

The requested accommodation(s) have been discussed with the employee's supervisor, and approval for the accommodation(s) has been obtained from the employee's supervisor, as indicated above.

Accommodation Type (Employee or Employer Suggested Option):	
Description:	
***Status** ☐ **Approved** ☐ **Denied- Employer** ☐ **Declined – Employee** ☐ **Implemented**	
This disability accommodation request was reviewed by the Legislative Human Resources Office (LHRO).	
LHRO Agent Signature:	**Date:**