

**City of Yucaipa
Employment Application
REQUEST FOR REASONABLE ACCOMMODATION FORM
APPLICATION OR EXAMINATION PROCESS**

Alternative formats and/or assistance in filling out this form are available upon request.

INSTRUCTIONS: If you are disabled as defined by the Americans With Disabilities Act (ADA) and/or California Fair Employment and Housing Act (FEHA) and wish to request accommodation in the application and/or examination process, please complete the following form.

POSITION APPLIED FOR: _____ **DATE OF REQUEST:** _____

APPLICANT NAME: _____
Last First MI

MAILING ADDRESS: _____
Number Street
City County State Zip Code

HOME PHONE: _____ **OTHER PHONE:** _____

ACCOMMODATION(S) REQUESTED

1. The following are examples of testing accommodations that may be possible. Please check below the accommodation(s) that you are requesting:

Visual/Learning

- Marker (someone to mark answers)
- Reader
- Separate Room
- Extra Time (Additional time requested):

Hearing

- Interpreter
- Separate Room

Mobility

- Testing room as close as possible to entrance or restroom
- Personal Attendant (to be provided by applicant)
- Wheelchair Access (accessible test area for applicants who use wheelchairs)
- Special Seating
- Marker (someone to mark answers)

Please describe below other accommodation(s) requested:

Please complete the front and back of this form and return the completed form to the City's Administrative Services Department (ATTN: Sherry Washburn) no later than five days prior to the examination. Documentation of the need for accommodation is required solely for the purpose of establishing that you have a disability and that the disability necessitates a reasonable accommodation. PLEASE NOTE: You do **NOT** need to complete the back of this form if your disability is obvious. The City reserves the right to provide an alternative reasonable accommodation that meets the applicant's needs.

I declare under penalty of perjury under the laws of the State of California that I have a disability that requires reasonable accommodation which will be met by the accommodation(s) described above.

DATED: _____ **SIGNATURE:** _____

NOTE: All information will be kept CONFIDENTIAL. If you are hired and later need an accommodation to perform an essential function during your employment, you must submit a separate request to the Administrative Services Department.

Please Note: If your disability is obvious, it is **NOT** necessary for you to have this side of this form completed.

INSTRUCTIONS: This side of the form is to be completed by a medical doctor, psychologist, learning consultant, etc., as appropriate.

Examinations for employment with the City of Yucaipa are administered on the basis of fairness, merit and equal opportunity. They are often highly competitive and candidates are ranked on hiring rosters or eligibility lists based on their total test score. The applicant who has signed the other side of this form has filed for such an examination, and has indicated that he/she needs accommodation under the Americans With Disabilities Act (ADA) and/or the California Fair Employment and Housing Act (FEHA). Whenever possible, reasonable testing accommodations that can be supported are provided to job applicants with disabilities.

Please review the applicant's medical and/or educational history (as appropriate). If you support the applicant's claim of need for reasonable accommodation under the ADA/FEHA, please complete the information requested below and return the signed form to the applicant. (Note: The qualified professional may submit all requested information in a separate letter on his/her official letterhead in place of completing this form.)

APPLICANT NAME (Print): _____

I certify that the above-named individual is disabled as defined by the ADA and/or FEHA. I recommend that the following accommodations be provided to this individual during the application and/or examination process:

My qualifications to provide this recommendation for reasonable accommodation are as follows:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATE SIGNED: _____ **SIGNATURE:** _____

COMPLETE NAME OF MEDICAL DOCTOR, PSYCHOLOGIST, LEARNING CONSULTANT, ETC., AS APPROPRIATE (Print): _____

BUSINESS NAME: _____

BUSINESS ADDRESS: _____

Number

Street

City County State Zip Code

BUSINESS PHONE: _____ **OTHER PHONE:** _____

SPECIALTY: _____ **CERTIFICATE/LICENSE NO.** _____

STATE OF ISSUANCE: _____