

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

**HRSA CONFIRMATION OF REQUEST FOR REASONABLE ACCOMMODATION**

1. Employee's Name:
2. Date of Request:
3. Office/Bureau/Division:
4. Employee's Job Title:
5. Employee's Series:
6. Employee's Grade:
7. Employee's Telephone Number:
8. Employee's Room Number:
9. Employee's Email Address:
10. If Applicable, Name of Third Party Requester:  
Check Appropriate Box:     Health Care Provider     Family Member     Representative
11. Third Party Requester's Telephone Number:
12. Accommodation Requested (*Be specific - e.g., ergonomic chair, telework, interpreter*):
13. Reason for Request:
14. Explain Any Time-Sensitive Issues Relating to Request:
15. Supervisor's Name (*Please Print*)/Date/Signature:
16. Supervisor's Telephone Number:

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**FOR OEOCRDM USE ONLY**

RA Coordinator:

EXPLANATION OF ANY TIME SENSITIVE ISSUES RELATING TO THE REQUEST:

RA Case #: