

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**HRSA REQUEST FOR REASONABLE ACCOMMODATION**

1. NAME (*Applicant or Employee*):
2. DATE OF REQUEST:
3. OFFICE/BUREAU/DIVISION:
4. JOB TITLE:
5. SERIES:
6. GRADE:
7. TELEPHONE NUMBER:
8. ROOM NUMBER:
9. IF APPLICABLE, NAME OF THIRD PARTY REQUESTER:  
CHECK APPROPRIATE BOX:     Health Care Provider     Family Member     Representative
10. THIRD PARTY REQUESTER'S TELEPHONE NUMBER:
11. SUPERVISOR'S NAME:
12. SUPERVISOR'S TELEPHONE NUMBER:
13. ACCOMMODATION REQUESTED (*Be specific - e.g., ergonomic chair, flexi place/time, interpreter*):
  
14. REASON FOR REQUEST:

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**FOR OEOCRDM USE ONLY**

RA Coordinator:

EXPLANATION OF ANY TIME SENSITIVE ISSUES RELATING TO THE REQUEST:

RA Case #: