Request For Reasonable Accommodation

To be completed by employee requesting an accommodation for their own medical condition. Send completed document to accommodations-req@pge.com.

SECTION A: TO BE COMPLETED BY EMPLOYEE	
NAME OF EMPLOYEE	CLASSIFICATION/JOB TITLE
WORK LOCATION/SUPERVISOR	WORK TELEPHONE NUMBER/EMAIL
ACCOMMODATION(S) REQUESTED (Be as specific as possible, for example adaptive equipment, reader, interpreter, training, schedule change, etc.):	
REASON FOR REQUEST (Please do not disclose your diagnosis; explain your disability-related limitations and how this accommodation will help you do your job.)	
IS YOUR LIMITATION: Permanent Temporary Unknown	ANTICIPATED RECOVERY DATE (if any)

SECTION B: CERTIFICATION FROM PHYSICIAN/HEALTH CARE PROVIDER

For completion by the health care provider: please provide a letter or verification addressing the following:

1. Verification that the employee has a disability (but not the diagnosis).
2. Description of how the employee's limitations impair the ability to perform the duties of the job and indication of whether these limitations are temporary or permanent.
    a. If temporary, state when they are expected to end.
3. Recommendation of specific reasonable accommodation(s).

Note: Use the space below or attach a letter or verification, which will be kept confidential.

DATE ACCOMMODATION TO BEGIN	DATE ACCOMMODATION TO END OR CONTINUOUS
NAME OF HEALTH CARE PROVIDER	SIGNATURE OF HEALTH CARE PROVIDER