

**APPENDIX D**  
**SUPERVISOR'S RESOLUTION OF EMPLOYEE'S REASONABLE**  
**ACCOMMODATION REQUEST**

1. Employee's name requesting reasonable accommodation: \_\_\_\_\_
2. Accommodation(s) requested:
  
3. Accommodation(s):
  - Approved as specifically requested
  - If approved but different from original request  
Identify the alternative accommodation(s): \_\_\_\_\_
  - DeniedIf denied, state reason(s):
  
4. If an alternative accommodation was offered, indicate whether it was:
  - Accepted
  - Rejected
5. Request denied because: (may check more than one box):
  - Requestor does not have a Rehabilitation Act disability
  - Accommodation ineffective
  - Accommodation would cause undue hardship
  - Medical documentation inadequate
  - Accommodation would require removal of essential function
  - Accommodation would require lowering performance or production standard
  - Other (Please identify)
  
6. Detailed reason(s) for denial (Must be specific, e.g., why accommodation would be ineffective or cause undue hardship):

7. If supervisor offered an accommodation that is different from the one originally requested, explain: (a) the reasons for the denial of the accommodation originally requested; and (b) why the alternative accommodation would be effective.

8. An individual who disagrees with the resolution of the request may ask the Director of the Office of Human Resources to reconsider that decision within 5 business days of receiving the " Resolution" form. Note that requesting reconsideration does not extend the time limits for initiating administrative, or statutory claims.

9. If you are dissatisfied with the resolution and wish to pursue administrative, or statutory claims, you must take the following steps:

For an EEO complaint pursuant to 29 C.F.R. § 1614, contact an EEO counselor in the Office of Equal Opportunity within 45 days from the date of receipt of this Form or a verbal response (whichever comes first).

Name of Appointing Authority Official: \_\_\_\_\_

Signature of Appointing Authority Official: \_\_\_\_\_

Date reasonable accommodation was denied or approved: \_\_\_\_\_

**CITY OF NEW ORLEANS**  
**REASONABLE ACCOMMODATION INFORMATION REPORTING FORM**

Employee's name requesting accommodation: \_\_\_\_\_

Employee's department: \_\_\_\_\_

1. Reasonable accommodation: (check one)

Approved (Whether it is what was originally requested or an alternative)

Denied

(Attach copy of the "Supervisor's Resolution of Reasonable Accommodation Request" form.)

2. Date accommodation requested: \_\_\_\_\_

Who received the request? \_\_\_\_\_

3. Date accommodation request referred to Assistant Chief Administrative Officer, if applicable:

\_\_\_\_\_

4. Determined that individual

Does have a disability as defined by the Rehabilitation Act

Does not have a disability as defined by the Rehabilitation Act

No disability determination made

5. Date accommodation approved or denied: \_\_\_\_\_

6. Date accommodation provided (if different from date approved): \_\_\_\_\_

7. If time frames outlined in the Procedures were not met, explain why.

8. Job held or desired by individual requesting reasonable accommodation (including occupational series, grade level, and office):

9. Accommodation needed for: (check one)

Application process

Performing job functions or accessing the work environment

Accessing a benefit or privilege of employment (e.g., attending a training program or social event)

10. Accommodation(s) requested:

11. Accommodation(s) provided (if different from what was requested):

12. Cost of accommodation provided: \_\_\_\_\_

13. Was medical information required to process this request? If yes, explain why.

14. Sources of technical assistance, if any, consulted in trying to identify possible reasonable accommodations (e.g., Job Accommodation Network, disability organization):

Comments

Please attach all documentation connected with this request.