ADA Reasonable Accommodation Request Form

Date: _____

Employee's Name: _____

Phone: _____ Email: _____

Job title: _____ Department: _____ Department

Head: _____

Describe the nature, extent, and duration of your disability:

_____

_____

Describe the accommodations you believe are needed to enable you to perform the essential functions of this job:

_____

_____

Provide the name, address, telephone, and email of your health care provider. The provider may receive a request from us for information regarding your impairment/disability and recommendations for accommodations.

_____

_____

_____

Attach any supporting documentation that may be helpful in evaluating this request for accommodation. (Doctor notes, etc.)

I authorize the release of information regarding my disability to Pamela Shapiro, Cumberland County Personnel Director, as deemed necessary to facilitate this request for accommodation.

Employee signature: _____

Date: _____

Complete and return with any supporting documentation to pamelash@CumberlandCountyNJ.gov

08.2026