



Request for Temporary Transitional Duty for ADA Accommodation

Part A: (To be completed by employee and given to the immediate supervisor)

Employee Information

Full Name:	
Employee Number:	Department:
Current Position Title:	Phone Number:

I am requesting a temporary light duty assignment to accommodate an injury or illness and I have attached the appropriate medical documentation from my treating physician to support my request.

I understand that my supervisor and Madison County is under no obligation to create a transitional position, but if such a position is identified to fit my physical restrictions, it is an ADA accommodation. I also understand that my request will be denied if it creates an undue hardship to my department.

I further understand that my work hours may be changed in order fit the accommodated position and that I will be required to meet the same quantitative and qualitative standards of work and attendance as other employees in my department.

Physician's Name:	Physician's Phone Number:
Date You Are Expected to Return to Full Duty:	
Employee Signature:	Date:

Part B: (To be completed by the department head and submitted to Madison County HR with a copy provided to the employee)

After reviewing the medical restrictions from the employee's treating physician and evaluating the workload and needs of the department, my determination is that a temporary transitional position is available from:

MONTH / DAY / YEAR	to	MONTH / DAY / YEAR
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(maximum of thirty (30) calendar days)

Please describe the duties the employee will be doing while in the transitional position:

If a transitional position is not available, please provide the reason(s):

Department Head Signature:	Date:
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