



Request for a Temporary Transitional ADA Accommodation

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

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 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.

Employee Name (Print): _____ Department: _____

Phone Number Where I Can Be Reached: _____ Current Position Title: _____

Date You Are Expected to Return to Full Duty: _____ Physician's Name: _____

Employee's Signature: _____ Date: _____

Part B: *(To be completed by the department head and submitted to the Personnel Department 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 _____ to _____ (maximum of thirty (30) calendar days)

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

Is not available for the following reasons:

Department Head Signature: _____

Work Flow: Employee > Immediate Supervisor > Personnel Department