USAGM FORM # 1

CONFIRMATION OF REQUEST FOR REASONABLE ACCOMMODATION

1. Applicant's or Employee's name: _____

2. Applicant's or Employee's phone number: _____

3. Date of request: _____**Employee's Office and Symbol:** _____

4. Supervisor and/or Division Director: _____

5. Job Title, Series, and Grade:_____

6. Accommodation requested, if known: (be as specific as possible, e.g., adaptive equipment, reader, interpreter, working space modification, etc.)

_____

_____

7. Reason for the request (please briefly explain the physical or mental impairment that is the basis of this request and how it affects your ability to either perform functions of the position or participate in Agency-sponsored activities):

_____

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8. If you believe the accommodation is time sensitive, please explain:

_____

(Return form to Disability Program Manager)
(Disability Program Manager will assign number)

9. Log No. _____

Privacy Act Statement

The Rehabilitation Act of 1973, 29 U.S.C. section 791, and Executive Order 13164 authorize collection of this information. The primary use of this information is to consider, decide, and implement requests for reasonable accommodation. Additional disclosures of the information may be: To medical personnel to meet a bona fide medical emergency; to another Federal agency, a court, or a party in litigation before a court or in an administrative proceeding being conducted by a Federal agency when the Government is a party to the judicial or administrative proceeding; to a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of the individual; and to an authorized appeal grievance examiner, formal complaints examiner, administrative judge, equal employment opportunity investigator, arbitrator or other duly authorized official engaged in investigation or settlement of a grievance, complaint or appeal filed by an employee.

DISPOSITION OF REASONABLE ACCOMMODATION REQUEST
(Must complete items 1-4 and 8; complete items 5-7 only if applicable)

1. Name of individual requesting reasonable accommodation (Requestor):

_____

2. Type(s) of reasonable accommodation requested: (Attach additional sheets if needed)

_____

3. The Disability Program Manager (DPM), in consultation with a medical professional if necessary, has determined the Requestor:

☐ Has a disability covered by the Rehabilitation Act

☐ Does not have a disability covered by the Rehabilitation Act

_____ _____
Name of DPM **Signature of DPM**

4. Accommodation(s):

☐ approved as specifically requested

☐ approved but different from original request

☐ denied

5. If the request is approved, indicate the duration:

☐ Long-term

☐ Temporary – if selected, specify when the accommodation expires:_____

6. If the request is denied, indicate general reason(s) for denial (may check multiple boxes):

- **Requestor does not have a disability covered by the Rehabilitation Act** ☐
- **Accommodation Ineffective** ☐
- **Accommodation Would Cause Undue Hardship** ☐
- **Requested Medical Documentation not Provided or Inadequate** ☐
- **Accommodation Would Require Removal of an Essential Function** ☐
- **Accommodation Would Require Lowering of Performance Standard** ☐
- **Accommodation can be fully met through other law or USAGM program** ☐
- **Other (please identify)** ☐

_____

7. If the request is denied, provide a rationale for denial (e.g., explain why accommodation is ineffective or causes undue hardship). Attach additional sheets if necessary

_____

_____

8. If the individual proposed one type of reasonable accommodation which is being denied, but Agency management offered a different type of reasonable accommodation, explain both the reasons for denial of the requested accommodation and why the accommodation the Agency offered would be effective. Attach additional sheets if necessary.

_____

_____

9. If you are dissatisfied with the decision to deny your request for accommodation, you have the following appeal rights:

a. **Request reconsideration from either the decision maker denying the request or the next level supervisor above the decision maker. Your request for reconsideration must be made within 5 business days from the date you received this form notifying you that your request has been denied, and/or**

b. **Contact the Office of Civil Rights (OCR) within 45 calendar days from the date you received this notice informing you that your request has been denied to:**
   - **Pursue an EEO Complaint pursuant to 29 C.F.R. 1614.**
   - **File a formal EEO complaint with OCR**

c. **For a bargaining unit employee,, file a written grievance in accordance with the provisions of the Collective Bargaining Agreement, or**

d. **Initiate an appeal to the Merit Systems Protection Board within 30 days of an appealable adverse action as defined in 5 C.F.R. § 1201.3.**

10. Signature block

_____ _____

Name of Deciding Official **Signature of Deciding Official**

Date: _____

USAGM FORM # 3

REASONABLE ACCOMMODATION INFORMATION REPORTING FORM

Name of individual requesting reasonable accommodation:_____

Office of Requesting Individual:_____

1. **Reasonable accommodation: (check one)**

   _____**Approved**

   _____**Denied (**if denied, attach copy of the written denial – See page 10 of the Reasonable Accommodation Procedures**)**

2. **Date reasonable accommodation requested:**_____

   Name and title of person who received the request:_____

3. **Date reasonable accommodation request referred to decision maker** (i.e., supervisor, Office/Division Director, or the Disability Program Manager)**:**_____

   Name of decision maker:_____

4. **Date reasonable accommodation approved or denied:**_____

5. **Date reasonable accommodation provided (if different from date approved):**

   _____

6. **If time frames outlined in the Reasonable Accommodation Procedures were not met, please explain why: (attach extra sheets if needed)**

   _____

   _____

   _____

   _____