

# WCPSS EMPLOYEE TEMPORARY ACCOMMODATION REQUEST FORM

*NOTE: If you have been injured at work, please contact the Workers' Compensation Office immediately at 919-533-7206.*

NAME:

POSITION:

EMPLOYEE #:

WORK SITE:

HOME ADDRESS:

EMAIL:

PHONE #:   
(w)  
(c)  
(h)

SUPERVISOR(s) & PHONE #:

*Have you received or are you applying for disability or workers' compensation benefits? \_\_\_\_\_*

What is the situation or condition that is prompting you to make an accommodation request?  
(e.g. nature of impairment; chronic or temporary condition, etc.)

Please describe the conditions of your current employment

Permanent or Temporary? Full or Part -Time? Contract status, if any: Hours/week, if applicable: Employment start date:
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Please list all of your responsibilities of your current employment

1. 2. 3.
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4.  
5.  
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Please describe the job responsibilities that would be affected by your accommodation request:

What specific accommodation request(s) are you proposing?

Please describe the anticipated length of the accommodation(s) requested.

Name and signature (or electronic signature) of person filling out form:

Date: \_\_\_\_\_

Medical certification, either a statement from a licensed health care provider or another applicable form, **MUST** be included for your request to be considered and needs to include, at the minimum, the following information:

- Specific accommodation(s) requested
- Statement of medical need for each of the accommodations requested
- Starting date for each of the accommodations requested
- Anticipated end date for each of the accommodations requested

**Please submit the completed form and medical certification statement to:**

Jeff Koweeck, Director of Employee Entitlements,  
WCPSS Human Resources - Employee Relations  
Crossroads I, 5625 Dillard Drive,  
Cary, NC 27518  
Fax: 854-1689 or [jkoweeck@wcpss.net](mailto:jkoweeck@wcpss.net)

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**Human Resources Section Only**

Result of Accommodation Request:

Signature and date:

*Revised 02/12/16*