



**Reasonable accommodation request form**

This form is an initial step in processing your request for an accommodation under Title II of the Americans with Disabilities Act. An accommodation is a reasonable modification or adjustment that enables a qualified person with a disability to enjoy the same access to employment, facilities, services, activities and programs that are enjoyed by persons without disabilities. To determine whether you are eligible for an accommodation under the ADA, the ADA coordinator may ask for documentation of your medical condition. Having a medical condition alone is not enough to make you eligible for an accommodation. Under the ADA, a person with a disability must have a physical or mental impairment that substantially limits one or more major life activities, such as breathing, eating, sleeping, walking, talking, manual tasks, hearing, caring for oneself, standing, lifting and reading.

The ADA requires the ADA coordinator to keep medical information confidential. However, the law allows the ADA coordinator to share information regarding your medical condition with individuals who are considered to have a legitimate need to know this information. These persons can include first aid and safety personnel, personnel investigating compliance with the ADA and other persons considered to have a legitimate need to know. The law does not prohibit you from voluntarily discussing your condition or medical information with others.

If accommodations are needed for an event, please allow as much time as possible prior to the event to process your request and make appropriate accommodations if they are approved.

**Participant/requestor information**

Date of request: \_\_\_\_\_ Affiliation: Resident, Visitor, Guest  
Volunteer, Employee\_\_\_\_\_

Requestor name: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Mail address: \_\_\_\_\_ Work or cell phone # \_\_\_\_\_

Preferred method of being contacted: \_\_\_\_\_

**Reasonable accommodation request details**

1) Do you believe you have a disability or impairment that may limit you from having equal access to Town programs, services or activities?

Yes \_\_\_\_\_ No \_\_\_\_\_

2) Please describe specific access barriers or problems you are experiencing that prevent you from having equal access, information or participation in Town services, programs or activities.

3) Please describe the major life activity that is limited by your impairment or disability.

4) Please describe the reasonable accommodation you are requesting or indicate if you need assistance in identifying possible accommodations.

I give consent to the Town of Castle Rock to request medical documentation from my health care provider, shown below, to support my request for a reasonable accommodation.

**Contact information for health care providers:**

\_\_\_\_\_ Phone number \_\_\_\_\_  
Health care provider name

\_\_\_\_\_ Date \_\_\_\_\_  
Requestor signature

Please submit the completed form by e-mail to [cjorgensen@crgov.com](mailto:cjorgensen@crgov.com), by fax to 303-660-1024 or by U.S. Postal Service or in person to:

**Catherine Jorgensen  
ADA coordinator  
Town of Castle Rock  
100 N. Wilcox St.  
Castle Rock, CO 80104  
303-660-1345  
[cjorgensen@crgov.com](mailto:cjorgensen@crgov.com)**

**ADA coordinator**

Personal meeting with requestor? Yes \_\_\_\_\_ No \_\_\_\_\_ Date: \_\_\_\_\_

Outcome of meeting: \_\_\_\_\_

Medical release and medical information provided and considered? \_\_\_\_\_

Reasonable accommodation denied after meeting with ADA coordinator \_\_\_\_\_

Reason for accommodation being denied \_\_\_\_\_

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

ADA coordinator signature