DENIAL OF REASONABLE ACCOMMODATION REQUEST

Date:

To: (Name of the requestor)

The reason your request has been is denied is because: ________________________________

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( ) However, PGCPS will provide the following accommodation as an alternative to your request.

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If you wish to accept this accommodation, notify the Compliance Officer within ten days of the date of this notice.

( ) PGCPS has determined that your requested accommodation, even if approved, will not permit you to perform the essential functions of your job. ________________________________

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( ) PGCPS has determined it needs additional information from your health care provider. ______

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( ) PGCPS would suffer undue hardship by approving the requested accommodation. _________

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( ) Other. ____

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If you wish to request reconsideration of this decision, please submit additional information to be considered and send to the Compliance Officer ten days from the date of the notice.

If your request for reconsideration is approved, you will be notified in writing.

If your request for reconsideration is denied, you may appeal to the Director of Labor Relations within ten (10) business days of the denial.

Name of Compliance Officer ____

Signature of Compliance Officer ____

Date: ________________________