

CUI (when filled in)

SECNAVINST 12713.14

CONFIRMATION OF REASONABLE ACCOMMODATION REQUEST**PRIVACY ACT STATEMENT**

Authority: 5 U.S.C. 301; 5 U.S.C. Chapters 11, 13, 29, 31, 33, 41, 43, 51, 53, 55, 61, 63, 72, 75, 83, 99; 5 U.S.C. 7201; 29 USC 791; 10 U.S.C. 136; E.O. 9830, as amended; 29 U.S.C. 79; 29 C.F.R. 1614.601, EEO Group Statistics; 29 CFR 1630.14, Medical Examinations and Inquiries Specifically Permitted; SECNAV Instruction 12713.14, Equal Employment Opportunity; and E.O. 9397 (SSN), as amended, and System of Records Notice (SORN) N12293-1.

Purpose(s): To provide relevant officials with the information to track, monitor, review, and process requests for reasonable accommodation.

Routine Uses(s): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records contained therein may specifically be disclosed outside the Department of Defense (DoD) as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: To the appropriate officials for the purpose of processing or responding to the request for reasonable accommodation and/or decisions related to such request. To officials and employees of the Equal Employment Opportunity Commission and/or other appropriate third parties responsible for investigating or adjudicating any cases that may result from a reasonable accommodation request. To unions recognized as exclusive bargaining representatives under the Civil Service Reform Act of 1978, 5 U.S.C. §§ 7111 and 7114, the Merit Systems Protection Board, the Office of the Special Counsel, arbitrators, the Federal Labor Relations Authority, and other parties responsible for the administration of the Federal labor-management program for the purpose of processing any corrective actions, grievances, or conducting administrative hearings or appeals. To the Office of Personnel Management (OPM), Office of Workers' Compensation, and Department of Veterans Affairs for the purpose of addressing civilian pay and leave, benefits, retirement deduction, and any other obligations. To an employee's private treating physician and to medical personnel retained by the DON to provide medical services in connection with an employee's health or physical condition related to employment. To the Occupational Safety and Health officials when needed to perform their duties.

Disclosure: Completion of this form is voluntary; however, failure to provide the requested information may result in an inability to process your reasonable accommodation request.

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information, **OMB 0703-0063**, is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

LOCATION (Physical Location of Requested Reasonable Accommodation):	DATE (DDMMYYYY):	REQUEST TYPE:
		☐ My Own Behalf ☐ On Behalf Of

PART I Requestor's Information (To be completed by Requestor or "On Behalf Of" Requestor)

1. NAME (Last, First, Middle Initial):	2. ORGANIZATION/DEPARTMENT:
3. UNIT IDENTIFICATION CODE (UIC):	4. DoD ID NUMBER (for employees only):
5. PHONE:	6. ALTERNATE PHONE:
7. OFFICIAL E-MAIL ADDRESS:	8. JOB TITLE AND PAY PLAN/SERIES/GRADE:
9. DESIGNATION OF PERSON ☐ EMPLOYEE ☐ APPLICANT ☐ CONTRACTOR	10. OFFICIAL MAILING ADDRESS:

PART II Details for Reasonable Accommodation (To be completed by Requestor or "On Behalf Of" Requestor)

11. DESCRIBE ANY IMPACT OF YOUR LIMITATIONS ON THE PERFORMANCE OF YOUR DUTIES OR ACCESSING A BENEFIT/PRIVILEGE OF EMPLOYMENT:

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12. DESCRIBE ANY ACCOMMODATION YOU BELIEVE WOULD ASSIST YOU IN THE PERFORMANCE OF YOUR DUTIES OR ACCESSING A BENEFIT/PRIVILEGE OF EMPLOYMENT:

13. IF REQUEST IS DUE TO A WORK-RELATED INJURY, PLEASE PROVIDE WORKERS' COMPENSATION CLAIM #:

14. DESCRIBE THE NATURE OF YOUR MEDICAL CONDITION AND YOUR WORK-RELATED LIMITATIONS (*include if limitations are permanent or temporary*):

I certify that the statements and information contained in this document and any attachments are true and complete to the best of my knowledge. I hereby give permission to release any information contained in this request to authorized officials with a need to know.

PART III Certification of Requestor and/or Designated Appointee or Approving Official

15. REQUESTOR'S PRINTED NAME:

16. REQUESTOR'S SIGNATURE:

17. DATE (DDMMYYYY):

18. SUPERVISOR'S PRINTED NAME:

19. SUPERVISOR'S SIGNATURE:

20. DATE (DDMMYYYY):

21. SUPERVISOR'S E-MAIL ADDRESS:

22. SUPERVISOR'S PHONE NUMBER:

The signature above acknowledges receipt of this request for accommodation and all attachments if any.

INSTRUCTIONS FOR COMPLETING THE CONFIRMATION OF REASONABLE ACCOMODATION REQUEST FORM**Notes:**

- The form can be completed by typing in the text fields/signing digital signature. For those who do not have access to a computer, the form can be completed by printing in the text fields/signing wet signature.
- Completed forms should be submitted to the servicing Reasonable Accommodation Point of Contact (RA POC) for processing and record keeping purposes.
- Please review the Privacy Act Statement and the Agency Disclosure Notice that are printed at the top of this form.
- For the purposes of the form, 'Requestor' is defined as the person requesting the reasonable accommodation, or a designated appointee acting on behalf of the Requestor.
- Attachments supporting the Reasonable Accommodation Request may be included by the Requestor or Designated Appointee.

COMPLETION OF THE FORM

- The Physical Location of the Requested Reasonable Accommodation should be entered in the 'LOCATION' block.
- The submission date of the Reasonable Accommodation Request form should be entered in the 'DATE' block.
- In the 'REQUEST TYPE' block, indicate whether the request is submitted by the Requestor ('My Own Behalf') or by a designated appointee acting on behalf of the Requestor ('On Behalf Of') by selecting the appropriate box.

Part I: Requestor's Information

Part I should be filled out and completed by the Requestor or "On Behalf Of" the Requestor. Consult with the supervisor and/or the servicing Reasonable Accommodation Point of Contact when needed.

1. Name (Last, First, Middle Initial): As stated.
2. Organization/Department: For employees, the requestor's current organization/department name. For applicants, the organization/department name of the position sought.
3. Unit Identification Code (UIC): For employees, the five-digit code associated with requestor's current employing organization. For applicants, the five-digit code associated with the organization of the position sought.
4. DoD ID Number: For employees only, please enter in your 10-digit DoD/EDIPI Number. For employees that do not have a DoD ID Number/EDIPI Number, please enter your Employee ID number.
5. Phone: As stated.
6. Alternate Phone: As stated.
7. Official Email Address: For employees, the requestor's work email address should be used. For applicants, the requestor's preferred email address should be used.
8. Job Title and Pay Plan/Series/Grade: If the requestor is an employee, the official work title, pay plan/series/grade information of the Requestor. If the requestor is an applicant, the official job title and pay plan/series/grade information of the position sought.
9. Designation of Person: Indicate whether the Requestor is an Employee, Applicant or Contractor.
10. Official Mailing Address: For employees, the requestor's work mailing address should be used. For applicants, the requestor's preferred mailing address should be used.

Part II: Details for Reasonable Accommodation

Part II should be filled out and completed by the Requestor or "On Behalf Of" the Requestor.

11. Describe any impact of your limitations on the performance of your duties or accessing a benefit/privilege of employment: As stated.
12. Describe any accommodation that you believe would assist you in the performance of duties or accessing a benefit/privilege of employment: As stated.
13. If the request is due to a work-related injury, the requestor shall provide the Workers' Compensation claim number: Enter the Workers' Compensation claim number if applicable. If the request is not due to a work-related injury, please enter "N/A," or the field can stay blank.
14. Describe the nature of your medical condition and the work-related limitations (*include if limitations are permanent or temporary*): As stated.

Part III: Certification of Requestor and/or Designated Appointee or Approving Official

Part III should be filled out and digitally signed by the Requestor (or their Designated Appointee) and (Requestor's Supervisor). Please include all information requested:

15. Requestor's Printed Name: As stated.
16. Requestor's Signature: Typing/signing a digital signature, or printing/signing a wet signature is permitted.
17. Date: Use 'DDMMYYYY' format.
18. Supervisor's Printed Name: As stated.
19. Supervisor's Signature: Typing/signing a digital signature, or printing/signing a wet signature is permitted.
20. Date: Use 'DDMMYYYY' format.
21. Supervisor's E-mail Address: The Supervisor's work email address should be used.
22. Supervisor's Phone Number: work phone number should be used