REQUEST FOR ACCOMMODATION UNDER THE PREGNANT WORKERS FAIRNESS ACT

1. NAME *(Last, First, Middle Initial)*:	2. DoD ID NUMBER (*for employees only*):
3. JOB TITLE AND PAY PLAN/SERIES/GRADE:	4. ORGANIZATION/DEPARTMENT:
5. PHONE:	6. UNIT IDENTIFICATION CODE (UIC):
7. OFFICIAL E-MAIL ADDRESS:	8. SUPERVISOR'S NAME:
9. ALTERNATE E-MAIL ADDRESS:	10. SUPERVISOR'S EMAIL:
11. LOCATION *(Physical Location)*:	12. DATE OF REQUEST:

TYPE OF REQUEST

DURING PREGANANCY		EXPECTED DELIVERY DATE IF KNOWN:
AFTER CHILDBIRTH		
FOR RELATED CONDITION		

Please describe the type of accommodation you are requesting:
Do you have medical documentation with specific job related medical restrictions? If so, please provide it along with this request.

Employee Signature:	Supervisor Signature:
Date Submitted to Supervisor:	Date Request Received:

Request for other programs which the employee may be entitled to, such as The Family and Medical Leave Act (FMLA) or Paid Parental Leave, must be submitted separately through the Human Resources Office.

This document contains PII. All individuals handling this information are required to protect it from unauthorized disclosure.