STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REQUEST FOR ACCOMMODATION BY PERSONS WITH DISABILITIES

1. Name: Telephone Number:
2. Mailing Address:
3. Email Address:
4. Person making request is: ☐ Applicant ☐ Attorney ☐ Witness ☐ Other:
5. WCAB/DWC Case No. and Unit (if applicable):
6. Date Accommodation Needed:
7. Location of Accommodation:
8. Specify impairment(s) or disability(ies) for which an accommodation is needed:

9. State accommodation being requested and how it accommodates the impairment/disability:

Date:

(SIGNATURE OF FORM FILLER)

(NAME OF FORM FILLER)

FOR OFFICE USE ONLY

Accommodation Provided? Y N Accommodation Used? Y N Date Provided_____

Accommodation effective? Y N If not, why not? _____

_____

Other comments: _____

_____

Name and Signature _____