STATE OF MARYLAND

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

Individual Request for Reasonable Accommodation

To request a reasonable accommodation, complete this form and present it to your Correctional Facility or Division of Parole and Probation (DPP) Regional ADA Coordinator.

☐ I am requesting reasonable accommodation due to my impairment. I understand that this is only a request, which will begin the inquiry into whether or not I am entitled to receive a reasonable accommodation. I also understand that there will be no immediate changes while my request is under consideration. I will be within my rights to file a grievance through the Incarcerated Individual Grievance Program should I not agree with the determination made regarding this request for reasonable accommodation.

Note: *A Facility ADA Coordinator or other authorized employee may assist an incarcerated individual or supervisee in the completion of this form.*

Requesting Individual's Name:	Program, Service, or Activity Requiring an Accommodation:	
Identifying Number (SID, DOC, or DPP #):	Location of Program, Service, or Activity:	
Address:	Phone Number (if applicable):	Request Date:

Please Check One: ☐ II ☐ Detainee ☐ Supervisee ☐ Visitor

What are the functional limitations that you experience as a result of your health condition?

NOTE: *SPECIFIC DISABILITY NEED NOT BE DISCLOSED*

My limitation(s) makes me unable to, or prevents me from:

I am requesting the following accommodation(s):

A request for accommodation may be denied if the Department cannot adequately evaluate the request without being provided with limited medical information relevant to the accommodation you may be seeking. Your medical information is private and cannot be revealed to Department employees without your permission. You may provide a waiver that allows the Department to obtain medical information from the Department's Office of Incarcerated Individual Health and Clinical Services or any other medical personnel, private physician, or clinic for the limited purpose of evaluating your accommodation request. You may revoke your waiver at any time by providing the Department with written notice of revocation.

☐ **I will** to provide a wavier that gives the Department limited access to my medical information for the purpose of evaluating my request for an accommodation.

Requestor's Signature: _____

☐ **I will not** provide a waiver that gives the Department access to my medical information for the purposes of evaluating my request for an accommodation. I understand that if the Department determines that my request cannot be properly evaluated without access to my medical information, my request for an accommodation may be denied for this reason.

Requestor's Signature: _____

Have you received any assistance in completing this form? ☐ Yes ☐
No If yes, please provide the following information for the person who assisted you:

Name:	Contact Information:
Date Assistance Received:	Relationship to You:

To Be Completed by the Facility or DPP Regional ADA Coordinator

Date Accommodation Request Received:	Response Due Date (7 calendar days from Date Received)

ADA Coordinator Name (Print)	*Location*	*Signature*

Distribution: Requesting Individual, Requesting individual's file, Case Manager or Supervising Agent, Facility or Regional ADA Coordinator, Approving Authority, and the Department ADA Coordinator