



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 _____