Pregnancy Accommodation Request Form

As a pregnant worker, you have certain rights and protections under the Pregnancy Discrimination Act, the Pregnant Workers Fairness Act, and the "PUMP" for Nursing Mothers Act. These protections are outlined in Board of County Commissioners Policy 52 (Pregnancy Non-Discrimination and Reasonable Accommodation for Pregnant Workers Policy) and Policy 59 (Lactation Accommodation Policy).

This form is intended to guide you through the process of requesting an accommodation under these policies and ensure we receive sufficient information to process your request. You can also make this request to your supervisor or manager verbally or in writing. Use of this form is not required.

First Name _____ Last Name _____

Email _____ Phone _____ Date _____

Department _____ Supervisor _____

Accommodation Start Date _____ Approximate Accommodation End Date _____

Please identify the limitation that is the physical or mental condition and that it is related to, affected by, or arising out of pregnancy, childbirth, or related medical condition.

What is your requested accommodation? (Please be specific)

The following healthcare practitioner is treating me or has provided the diagnosis for my pregnancy:

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____ Fax Number (Optional) _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the above-named physician to provide my employer, the Board of Lucas County Commissioners, with all medical information relating specifically to the health condition I have disclosed above as necessary for the employer to determine the need for an accommodation.

I understand that I have a right to revoke this authorization at any time by notifying the Lucas County Department of Human Resources in writing (One Government Center, Suite 450, Toledo, OH 43604). I understand that the revocation is only effective after it has been received by the Department of Human Resources. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

I understand that this authorization will expire one (1) year from the date signed or when my employment with the Lucas County Board of Commissioners ceases, whichever occurs first.

_____ _____

Employee Signature Date

Received by Human Resources Name _____ Date _____