N.C. DEPARTMENT OF PUBLIC SAFETY

ADA COORDINATOR'S LOG

EMPLOYEE'S NAME: _____ **POSITION:** _____

EMPLOYEE'S ADDRESS:_____

WORK LOCATION/DISTRICT: _____

DATE RECEIVED: _____

MEDICAL CONDITION: _____

ACCOMMODATION REQUESTED: _____

REQUEST FOR (6) WEEKS OR LESS: ☐ **YES** ☐ **NO**

TEMPORARY JOB ASSIGNMENT MODIFICATION APPROVED: _____

APPROVED UNTIL DATE: _____

REQUEST FOR MORE THAN (6) WEEKS, PERMANENT ACCOMMODATION, OR FOR AN UNDETERMINED PERIOD OF TIME: ☐ **YES** ☐ **NO**

DATE:	NOTES: