



# Tompkins County Department of Human Resources

125 East Court Street, Ithaca, NY 14850 | P: (607) 274-5526 | F: (607) 274-5401 | [www.TompkinsCountyNY.gov](http://www.TompkinsCountyNY.gov)  
*Inclusion through Diversity*

## RELIGIOUS REASONABLE ACCOMMODATION REQUEST FORM

(Submit to Supervisor, Department Head or Commissioner of Human Resources)

This form is to be used by, or in favor of, the Tompkins County employee. By completing this form, the County employee recognizes the need for, and is therefore requesting, an accommodation per the Civil Rights Act of 1964 (Title VII) and the New York State Human Rights Law. Completion of this form, and all the content herein, is to remain confidential between the employee, Supervisor, Department Head, and/or Department of Human Resources.

Employee Name: \_\_\_\_\_ Phone (home/work): \_\_\_\_\_

Department: \_\_\_\_\_ Position Title: \_\_\_\_\_

Department Head: \_\_\_\_\_ Date of Request: \_\_\_\_\_

**1. Please specify the religious belief, practice, or observance that is the basis for your request for accommodation.**

---

---

**2. Please specify the work requirement that conflicts with the religious belief, practice, or observance described above and explain the nature of the conflict.**

---

---

**3. Please describe the specific accommodation(s) that you are requesting at this time, including an explanation of how the requested accommodation(s) will enable you to meet your religious obligations without impacting your ability to meet the required/essential functions of your job.**

---

---

**4. What are some other accommodation options that might address your needs?**

---

---

**5. Additional Comments and/or information (if any):**

---

---

---

---

I understand that all the information obtained by my employer during this process will be maintained and used in compliance with all Federal and State confidentiality requirements. I also understand that I may be required to provide my employer with information about religious practices, habits, or observances, and appropriate accommodations.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*[To signatory: Decisions regarding accommodations will be made within ten (10) business days of the receipt of this form. In the event of a delay that may be caused due to the need for additional conversation or documentation, accommodations will be made within ten (10) business days from the receipt of the additional documentation.]*

For Human Resources Use Only

Date Received: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Received by: \_\_\_\_\_ Reviewed By: \_\_\_\_\_