

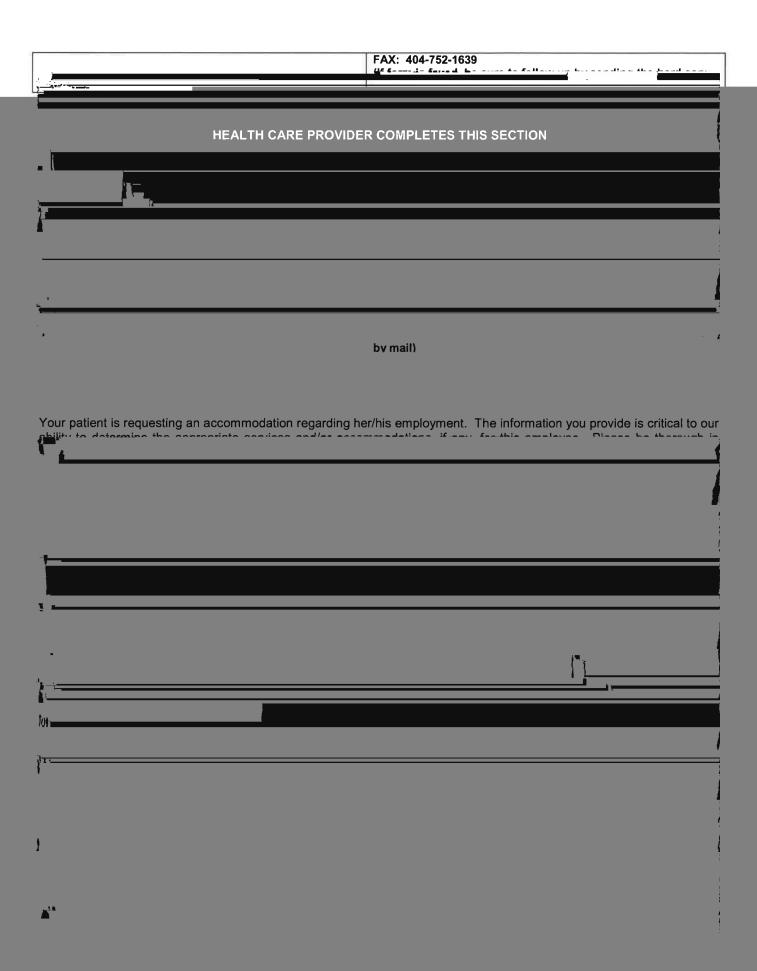
Office of Disability Services

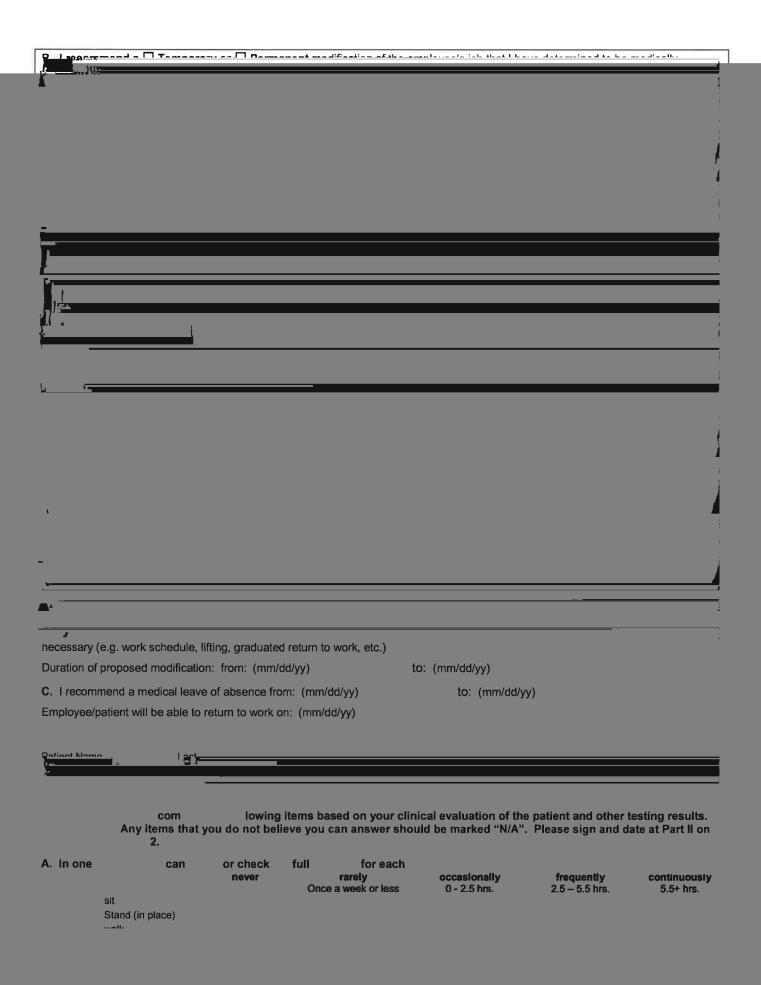
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Emp	loyee/Applicant Information	
Employee ID/Name:	Contact Number:	
Position Title:	Dept. ID/Name:	
Immediate Supervisor: Department Head:	Contact Number: Contact Number:	
	commodation Information	
1 Please identify the limitation(s)/impairment(s) that you believe are affecting your ability to pe	rform
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5	Has a physician, vocational rehabilitation specialist, or other health professional recommended a specific accommodation? Yes No
	If yes, please attach a copy of their recommendations.
Nato:	Ap individual's appet for engagemedation or a portiouser may change ever time, as a result of changes
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as re	individual's impairment, changes in the nature of the job, or changes in work location. What qualifies asonable in one set of circumstances may not qualify as reasonable in another. If and when
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	EMPLOY	EE COMPLETES THIS SECTI	ON.
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HEALTH CARE P	· · · · · · · · · · · · · · · · · · ·	TEMENT	
Name (Last)	(First)	(M.I)	Department
Employee's Job Title		Work Email	Work Phone
Work			
Name of Health Care Provider			Health Care Provider's Phone
Medicine and its authori	zed representatives, t	he following information related to	d disclose to the Morehouse School of my health care: the diagnosis(es) of ommendations, history, reports and
understand that it may l	he necessary for the S	School representatives to share this	information for nurnoses related to mu
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raguest far saasmmadet	ion of a physical or p	nunhalanisal impairmant—Lautharin	a tha Cabaal ta abasa this information





F. P	atient is able	to					
	Machii Drive a vehicle Work v	a stick-shift	Once	rarely a week or less	occasionally 0 - 2.5 hrs.	frequently 2.5 – 5.5 hrs.	continuously 5.5+ hrs.
G. F	Patient can us	se hand for repet	itive action such as				
<u>_</u>					INTAL COURSE	· TOT NEW	u pa
ř					ONE TIME	DURING ONE	SHIFT
	Not applicable o this patient		Left	Right	Left Righ		Right
		Single ng					
		Pushing & Pulling Fine Manipulating Keyboarding or					
			CADACITIES				
Patie	nt Name	Last	CAPACITIES First		MI		
Sta	tement of		(Include the	DSM-IVR diagnosis,) :		
	alth Care Provi	der: Please	thợ j ạ b g	१ १८ न्यस्तिकृत्यः (१ ०१ १०-१४)	g <u>an</u> ifina doi anif <u>gang</u>	n la	
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C.F.	
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If there are other restrictions you have not described above, please describe here:	
Anticipated duration of these restrictions?	
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Are these restrictions medically necessary? ☐ Yes ☐ No	
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OFFICE OF DISABILITY SERVICES

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Important Notices under HIPAA

