

Office of Disability Services

DISABILITY ACCOMMODATION REQUEST FORM

Employee/Applicant Information

Employee ID/Name:	Contact Number:
Position Title:	Dept. ID/Name:
Immediate Supervisor:	Contact Number:
Department Head:	Contact Number:

Accommodation Information

1 Please identify the limitation(s)/impairment(s) that you believe are affecting your ability to perform your job duties and participate in the application and selection process. Please include the

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.

~~Note: An individual's need for accommodation or a particular may change over time as a result of changes~~

in the individual's impairment, changes in the nature of the job, or changes in work location. What qualifies as reasonable in one set of circumstances may not qualify as reasonable in another. If and when ~~circumstances change, it is your responsibility to notify this office if you need, or continue to need,~~

SCHOOL OF MEDICINE

Morehouse School of Medicine | Office of Disability Services

EMPLOYEE COMPLETES THIS SECTION

HEALTH CARE PROVIDER STATEMENT

Accommodation

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

I hereby authorize the above-named health care provider to complete this form and disclose to the Morehouse School of Medicine and its authorized representatives, the following information related to my health care: the diagnosis(es) of relevant conditions, treatment plan(s), my ability to perform my work, recommendations, history, reports and correspondence.

I understand that it may be necessary for the School representatives to share this information for purposes related to my

request for accommodation of a physical or psychological impairment, I authorize the School to share this information

FAX: 404-752-1639

(If space is needed, please use following telephone number: _____)

HEALTH CARE PROVIDER COMPLETES THIS SECTION

by mail)

Your patient is requesting an accommodation regarding her/his employment. The information you provide is critical to our ability to determine the appropriate services and/or accommodations, if any, for this employee. Please be thorough in

Recommend Temporary Permanent modification of the employee's job that I have determined to be medically

[REDACTED]

necessary (e.g. work schedule, lifting, graduated return to work, etc.)

Duration of proposed modification: from: (mm/dd/yy) to: (mm/dd/yy)

C. I recommend a medical leave of absence from: (mm/dd/yy) to: (mm/dd/yy)

Employee/patient will be able to return to work on: (mm/dd/yy)

Patient Name: [REDACTED] Date: [REDACTED]

com lowing items based on your clinical evaluation of the patient and other testing results. Any items that you do not believe you can answer should be marked "N/A". Please sign and date at Part II on 2.

A. In one	can	or check never	full	for each rarely	occasionally	frequently	continuously
			Once a week or less		0 - 2.5 hrs.	2.5 - 5.5 hrs.	5.5+ hrs.
sit							
Stand (in place)							
walk							

10 OTHER RESTRICTIONS & EFFECTS OF MEDICATION

If there are other restrictions you have not described above, please describe here:

Anticipated duration of these restrictions?

Are these restrictions medically necessary? Yes No

[Redacted content]

If Yes, please explain, include the expected duration that employee will be restricted this for (excluded medication)

[Redacted content]

SCHOOL MEDICINE

OFFICE OF DISABILITY SERVICES

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

SCHOOL OF MEDICINE

Important Notices under HIPAA

I, _____ understand that I may revoke this authorization at any time by

(Employee's Name)
