MORE HOUSE
SCHOOL OF MEDICINE

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:**

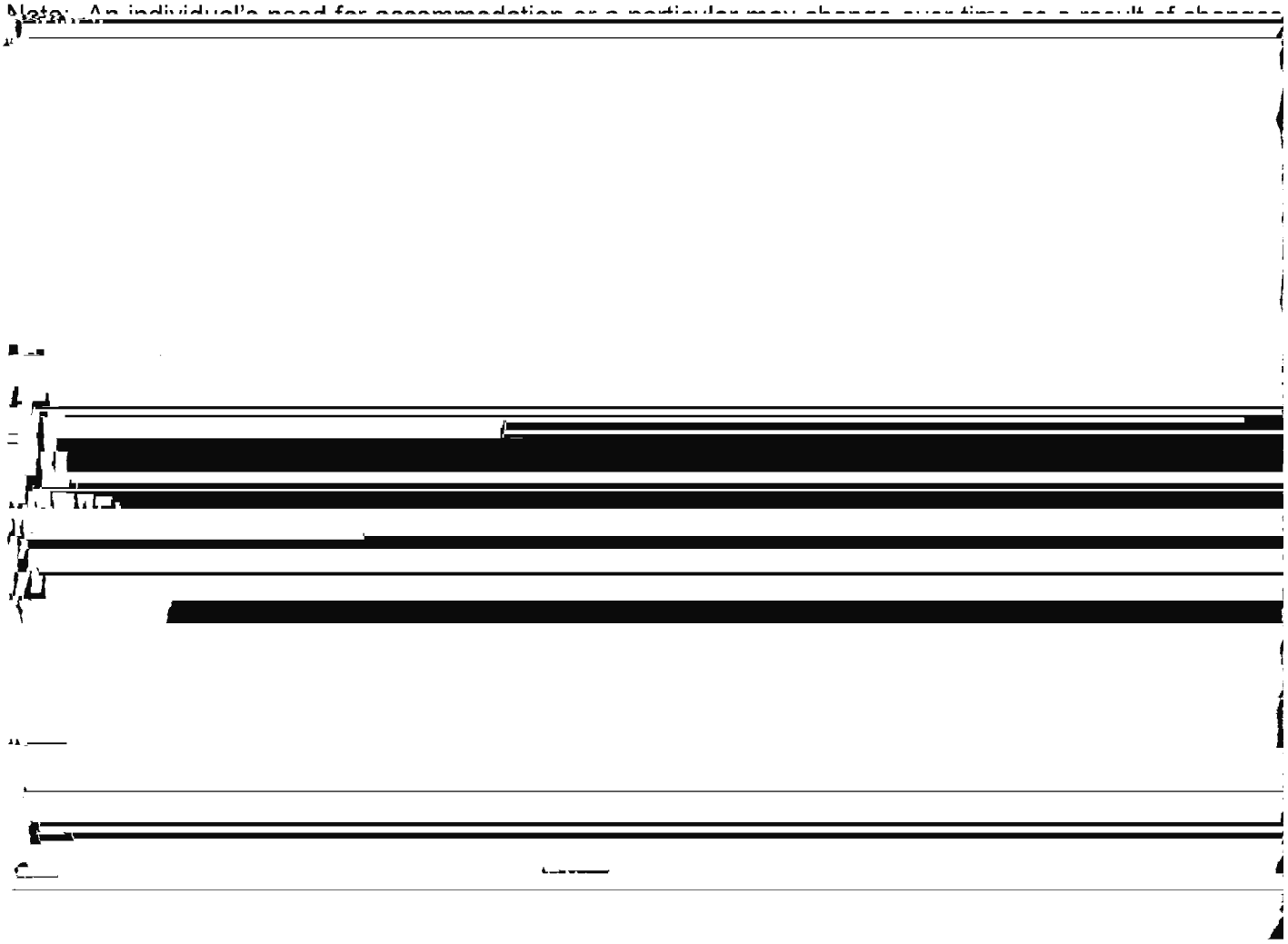
Accommodation Information

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

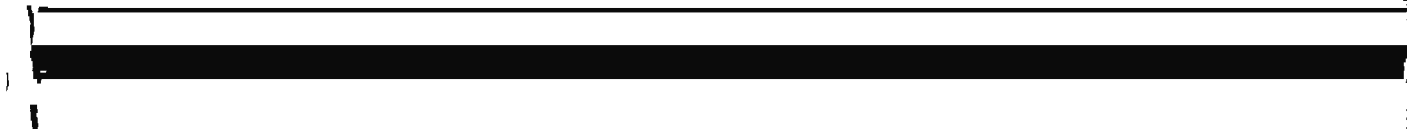
5 Has a physician, vocational rehabilitation specialist, or other health professional recommended a specific accommodation? Yes _____ No _____

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 a



SCHOOL O MEDICINE

[redacted]

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

[redacted]

FAX: 404-752-1639

[redacted]

HEALTH CARE PROVIDER COMPLETES THIS SECTION

[redacted]

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

[redacted]

B. I recommend a ☐ Temporary or ☐ Permanent modification of the employee's job that I have determined to be medically

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 Last

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 full for each

	never	rarely Once a week or less	occasionally 0 - 2.5 hrs.	frequently 2.5 – 5.5 hrs.	continuously 5.5+ hrs.
sit					
Stand (in place)					
walk					

F. Patient is able to

	never	rarely Once a week or less	occasionally 0 - 2.5 hrs.	frequently 2.5 – 5.5 hrs.	continuously 5.5+ hrs.
Operate Heavy Machinery					
Drive a stick-shift vehicle					
Work with or near moving machinery					

G. Patient can use hand for repetitive action such as

[redacted]

		ONE TIME		DURING ONE SHIFT	
☐ Not applicable to this patient	**Left**	**Right**	**Left**	**Right**	**Left**	**Right**
Single ng						
Pushing & Pulling						
Fine Manipulating						
Keyboarding or						

CAPACITIES

Patient Name Last First MI

Statement of *(Include the DSM-IVR diagnosis)*:

How often is patient receiving treatment from you and/or another health care provider for this condition?

Health Care Provider: Please

Patient has the ability to [redacted]

V. 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]

SCHOOL MEDICINE

OFFICE OF DISABILITY SERVICES

[redacted]

SCHOOL F MEDICINE

Important Notices under HIPAA

I, (Employee's Name) understand that I may revoke this authorization at any time by

[redacted]