

**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

[Redacted content]

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 at a particular time may change over time as a result of changes~~

[Redacted area containing multiple horizontal black bars covering text.]

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,

[Redacted area containing multiple horizontal black bars covering text.]

# SCHOOL OF MEDICINE

Merhaba 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 Merhaba School of

FAX: 404-752-1639

(If Form is faxed, 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							









