THE UNIVERSITY OF TENNESSEE KNOXVILLE

Reasonable Workplace Accommodation Request Overview

Faculty, Staff, & Graduate Student Employees

CONFIDENTIAL

This form is the initial step in an employee's request for an accommodation in the workplace based on a disability. This will assist the University in determining whether, or to what extent you are eligible for an accommodation in order to perform one or more of the essential functions of your job safely and effectively. Following your completion and submission of these forms, the Office of Equity and Diversity will participate with you in a process that will involve interaction with you, your supervisor(s), and if necessary, your health care providers. This process may also include health care professionals or subject-area specialists identified by the University as accommodations suggested by the employee's health care providers.

I, ______________________________________, give the University of Tennessee permissions to take steps necessary to explore whether I may be covered under reasonable accommodation definitions and standards under University policy and the Americans with Disability Act. This permission acknowledges that the office responsible for coordinating such employment requests, the Office of Equity and Diversity, may need to engage with other appropriate University offices. I understand that all information and records obtained during this process will be maintained and handled in accordance with any applicable confidentiality requirements.

I further understand that I am required to complete and sign a "medical information request" form (Form3) giving the University permission to consult with my health care professional(s) as necessary before the University can proceed with my request. Forms 1, 2 and 3 must be submitted to the Office of Equity and Diversity, 1840 Melrose Avenue, Knoxville, TN 37996 oed@utk.edu Fax: 865-974-0943.

___________________________________ ________________________

Employee Signature Date

Checklist of all documents to be submitted for file to be considered complete (please initial).

________Overview

_______ Accommodation Request (Form 1)

_______ Medical Release (Form 2)

_______ Health Care Provider Information (Form 3)

_______ Position Description-please email to oed@utk.edu

THE UNIVERSITY OF TENNESSEE KNOXVILLE

Reasonable Workplace Accommodation Request- Form 1

Faculty, Staff, & Graduate Student Employees

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Employee Name:_________________________________ Email:_______________________________

Preferred phone:____________________ Work Address:______________________________________

Classification: _________Faculty _________ Staff _________GTA/GRA

Job Title and Department:____

Department Head:_________________________________ Email:_______________________________

Supervisor:_______________________________________ Email:_______________________________

Work Schedule:____

_________ New Request for Accommodation ___________ Extension/Alteration of existing request

If extension/alteration is requested, please describe current accommodations that are in place:

____

____

____

Nature of condition: ______Permanent ______Temporary

If temporary, please list number of weeks or months:____

Date of most recent doctor's visit (in relation to disability):____

Identify your physical and/or mental impairment(s) for which you are requesting accommodation:

____

____

Explain how the impairment(s) listed above affects your ability to perform the essential function(s) of your job: ____

____

List the accommodation(s) you are requesting in order to perform the essential functions of your job:

____

____

____

THE UNIVERSITY OF TENNESSEE KNOXVILLE

Medical Information Release- Form 2

Faculty, Staff, & Graduate Student Employees

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I give permission to my health care provider(s) to release the following information to the University of Tennessee, Knoxville, to assist the University in determining whether and to what extent, I may be eligible for a reasonable workplace accommodation.

I further give my health care provider(s) permission to discuss my health conditions with the University of Tennessee, Knoxville, if necessary for clarification purposes.

_____________________________________ _________________________

Employee Signature Date

____

Print Employee Name

THE UNIVERSITY OF TENNESSEE KNOXVILLE

Medical Information- Form 3

Faculty, Staff, & Graduate Student Employees **To be completed by physician or health care provider**

CONFIDENTIAL

Employee Name:____

The University of Tennessee (University) employee named above has requested that the University provide him/her with a reasonable accommodation at the workplace based on a disability. A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. An employee making such a request must provide the University with current documentation of a disability. You are being asked by the employee to provide documentation by fully completing each section of the form. These questions will help determine 1) whether the employee has a disability; 2) whether a workplace accommodation is needed; and 3) what options may exist that would constitute an effective, reasonable accommodation.

The employee should provide you with a copy of his or her job description and functions. Please review the job description and functions, and any other information relative to the employee's work at the University in order to complete this form. The complete form may be returned to the employee, emailed directly to oed@utk.edu, faxed to 865-974-0943, or mailed to OED 1840 Melrose Ave. Knoxville, TN 37996.

1. Please identify the employee's physical or mental impairment(s):

2. Please describe the effects or limitations this impairment has on the employee's activities, if any:

3. Please describe whether the effects or limitations are permanent or temporary:

4. Please review the information supplied by the employee concerning his or her job duties. What limitation(s) is interfering with the employee's job performance?

THE UNIVERSITY OF TENNESSEE KNOXVILLE

Medical Information Form 3

Faculty, Staff, & Graduate Student Employees **To be completed by physician or health care provider**

CONFIDENTIAL

5. Please describe what job functions the employee is having trouble performing because of the limitations:

6. How does the employee's limitation(s) interfere with his or her ability to perform the job?

7. Are there any activities or job duties that would present a health or safety risk to the employee or others due to the impairment or its treatment?

8. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

9. Any additional comments?

_______________________________________ ___________________________

Signature of physician or care provider Date

____ _____________________________

Provider name (printed) Telephone

____

Provider Address