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 Equal Opportunity & Accessibility 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 Equal Opportunity & Accessibility, 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 Equal Opportunity & Accessibility, 1840 Melrose Avenue, Knoxville, TN 37996 eoa@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 eoa@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**

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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 eoa@utk.edu, faxed to 865-974-0943, or mailed to OEOA 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

Please submit form via: eoa@utk.edu | fax 865-974-0943 | EOA 1840 Melrose Ave. Knoxville, TN 37996