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 (Form 3) 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
Reasonable Workplace Accommodation Request- Form 1

Faculty, Staff, & Graduate Student Employees

CONFIDENTIAL

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:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
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
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 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?
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