EMPLOYEE MEDICAL FORM

THE UNIVERSITY OF TENNESSEE KNOXVILLE

Employee Name: _____

The University of Tennessee (University) employee named above has requested that the University provide him/her with 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 all sections of this form. These questions will help determine 1) whether the employee has a disability, 2) whether an 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/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 completed form may be returned to the employee or emailed to the The Office of Equal Opportunity & Accessibility (eoa@utk.edu).

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

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

3. Are the effects temporary, short-term, or long-term?

4. What limitations are interfering with the employee's job performance, if any?

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 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 the possible accommodations to improve job performance?

9. Any additional comments?

_____   _____

Signature of the physician or care provider   Date

_____   _____

Provider name (printed)   Telephone

Provider Address   Fax Number of Provider

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