UNIVERSITY OF KANSAS MEDICAL CENTER
EQUAL OPPORTUNITY OFFICE

EMPLOYEE INFORMATION (ADA) FORM

Name: _____ Date: _____

Home Address: _____

Department Name and Address: _____

Day Phone: _____ Evening Phone: _____

E-Mail Address: _____ Cell Phone (if applicable): _____

Employee Information

Job Title: _____

Supervisor's Name and Job Title:_____

Supervisor's Phone Number: _____

Medical Information

Medical/Psychiatric Condition(s): _____

_____

Impact of Condition(s) on Work Performance, Attendance, and/or Conduct:

_____

_____

I understand information provided to the KUMC EOO will generally remain strictly confidential. However, the EOO may disclose limited information on a need-to-know basis to support the accommodation process.

_____ _____

Signature Date

Referred by: ☐ Self ☐ Supervisor ☐ Friend ☐ Dean ☐ Faculty ☐ Other

Revised 04/2004