KU MEDICAL CENTER
The University of Kansas

Office of Compliance
Equal Opportunity Office

Note: Please obtain from your supervisor a copy of your current position description which includes a list of essential job duties and the physical and cognitive/mental requirements of the position. Provide that documentation and this form to your physician(s).

Return to:

Carol Wagner, EO/Disability Specialist
University of Kansas Medical Center
Mail Stop 2014
3901 Rainbow Blvd.
1040 Wescoe
Kansas City, KS 66106
Phone: 913-588-1206
Fax: 913-588-1224
TDD: 913-588-7963

CONFIDENTIAL
REQUEST FOR ACCOMMODATION

PLEASE PRINT

TO BE COMPLETED BY EMPLOYEE

Name:	Unit/ Dept:
Home Address:	Supervisor:
Home Phone:	Campus Phone:
E-mail Address:	

Type of Accommodation Requested to perform the Essential Functions of your job (Please check):

☐ Work Site Modification ☐ Acquisition or Modification of Assistive Device
☐ Job Restructuring ☐ Other: (Please describe) ____________________

I authorize Dr.(s) ____________________to release information from my patient file to the KUMC EO/Disability Specialist for the purpose of determining appropriate job accommodation(s) for my condition.

Signature: ____________________ **Date:** ____________________

Typed or Printed Name: ____________________

FOR OFFICE USE ONLY **Received by:**____________________ **Date:** ____________________

TO BE COMPLETED BY MEDICAL PRACTITONER

Diagnosis of condition(s): ____________________

Will the condition(s) result in a long term or permanent condition? ☐ Yes ☐ No

Is the patient taking medication or treatments that would be expected to affect job performance, or would pose a direct threat or be regarded as a safety risk? (See attached list of essential job duties and activities/abilities required to perform these duties).
☐ Yes ☐ No

If yes, please explain): ____________________

State whether or not the condition(s) limit(s) the patients' ability to perform the essential functions of the job): ____________________

Are additional functional limitations anticipated? ☐ Yes ☐ No. If yes, please explain. ____________________

Accommodations Recommended: (See reverse side for a list of possible accommodation(s), attach an additional page, if necessary)
Please check:
☐ Work Site Modification ☐ Acquisition or Modification of Assistive Device(s)
☐ Job Restructuring
☐ Other: (Please describe)____________________

Signature____________________ Address____________________ Date_________

1 White original– EOO office 2 Yellow – Employee copy 3 Pink – Medical Practitioner copy

Instructions for completing form "Request for Accommodation"

To be completed by employee:

Provide the name of the person requesting the accommodation and other pertinent information to help contact the persons necessary to facilitate the accommodation.

To be completed by the medical practitioner:

This section is to be completed only when the condition and functional limitations are known. It is not necessary for the employee to authorize his/her treating medical practitioner to release information if completion of this section is not needed. The cost of an examination is borne by the employee requesting the accommodation. Determination of need for a doctor's statement will not be used in retaliation for an employee's request for accommodation.

Accommodations recommended: Job accommodations can include many factors (e.g. flex-time or job restructuring.) Applicable Federal and State laws require that no otherwise qualified person, solely by reason of disability, be subjected to discrimination under any program receiving federal financial assistance. These laws also require that "reasonable accommodation" be provided to the **known** physical or mental limitations of a disabled employee. Requested accommodations must be described and submitted in writing. Performance of essential duties provides the framework for evaluating requested accommodations. The determination of the "reasonableness" of the requested accommodation will subsequently be made.

POSSIBLE ACCOMMODATIONS:

Work site modification
Acquisition/modification of assistive device(s)
Reduction in work hours
Leave of absence
Interpreter
Architectural modification
Job restructuring
Modified work schedule
Reader
Other ●●

●● Every request for an accommodation of a disability will be evaluated on a case by case basis. The above list is not a complete list; other accommodations will be considered after consultation with the person making the request, the department, and, if necessary, the medical practitioner.