MOREHOUSE SCHOOL OF MEDICINE

Office of Disability Services

DISABILITY ACCOMMODATION REQUEST FORM

Employee/Applicant Information

Employee ID/Name: **Contact Number:**

Position Title: **Dept. ID/Name:**

Immediate Supervisor: **Contact Number:**

Department Head: **Contact Number:**

Accommodation Information

1. Please identify the limitation(s)/impairment(s) that you believe are affecting your ability to perform your job duties or, to participate in the application and selection process. Please include the expected duration of the limitation(s) or impairment(s.) It is not necessary to indicate a medical diagnosis or condition.

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2. Please describe the accommodation(s) you are requesting, as well as any alternative accommodations, and how long you believe you will need the accommodation.

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3. Explain how the requested accommodation(s) will allow you to perform the essential functions of your job, or will allow you to participate in the application and selection process:

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4. Are there any essential functions of the job that you will be unable to perform, or aspects of the selection process you will be unable to complete, with or without the requested accommodation(s)? Please explain.

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5. Has a physician, vocational rehabilitation specialist, or other health professional recommended a specific accommodation? Yes _____ No _____

   If yes, please attach a copy of their recommendations.

Note: An individual's need for accommodation or a particular may change over time as a result of changes in the individual's impairment, changes in the nature of the job, or changes in work location. What qualifies as reasonable in one set of circumstances may not qualify as reasonable in another. If and when circumstances change, it is your responsibility to notify this office if you need, or continue to need, a reasonable accommodation.

Acknowledgement

I give Morehouse School of Medicine's Office of Disability Services permission to explore coverage and reasonable accommodations, if any, under the Americans with Disabilities Act. This may include speaking to appropriate School personnel and/or my health care professional. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that I will be required to provide appropriate documentation of my impairment, including the impact of the functional limitations on my ability to perform the essential functions of my job.

I understand that it will be my responsibility to complete a medical release authorization and to provide a medical certification, if required, to the MSM Office of Disability Services for my request to be evaluated. I further understand that the MSM Office of Disability Services will evaluate and respond to me based upon the information that I provide. The information provided by me is true and correct to the best of my knowledge.

Employee/Applicant Signature: _____ Date: _____