# REQUEST FOR REASONABLE ACCOMMODATION

Murray State University Office of Equal Opportunity

## SECTION I-TO BE COMPLETED BY APPLICANT

Name: ______________________________________________________________Date:_________________

Campus Address: _______________________________________ Campus/Local Phone: __________________

Alternative/Cell Phone: __________________________________ Home Phone:_________________________

Home Address: ______________________________________________________________________________

City_________________________________________ State____________ Zip Code___________

E-Mail_____________________________________________________________________________________

**Current Status:** ☐ Faculty/Staff ☐ Retiree ☐ Other:____________________________________________

☐ Student (*indicate classification*): ☐FR ☐SO ☐JR ☐SR ☐Other:____________________

**Term:** ☐ Fall Year:____ ☐ Spring Year:____ ☐ Summer Year:____ **Class Info**: ☐ Attach a copy of class schedule

Current Department of Employment:_____________________________________________________________

Job Title/Classification:______________________________________________________________________

Work Location: _____________________________________________________________________________

Supervisor's Name:_____________________________________________ Phone:______________________

***Work Accommodation Requests:*** ☐ Attach the ___official job description from Human Resources ___essential job function documents from Human Resources and your ___work schedule including work days and times ___Section II completed by Human Resources

**A. I have the following physical or mental impairment(s)**: ________________________________________

___________________________________________________________________________________________

**B. That impairment restricts me as follows:** ____________________________________________________

___________________________________________________________________________________________

**C. As a result, I am unable to perform the following activity**________________________________**because I**

**cannot** _________________________________________________________________________________

**D. In order for me to engage in the activity mentioned in item C, I am requesting the following**

**accommodation** ___________________________________________________________________________

**By the signature below, I, the applicant, authorize the physician to complete Section III below, and to release information regarding my medical condition. I understand that I can revoke this authorization at any time by submitting a written revocation. A revocation will not apply to information that has already been disclosed in reliance on an authorization. I understand that once the information is disclosed pursuant to this authorization it may be re-disclosed by the recipient and the information will no longer be protected by HIPAA. This authorization will expire six (6) months subsequent to the day executed as indicated below.**

Signature of Applicant_______________________________________________________ Date ___________

## SECTION II- TO BE COMPLETED BY HUMAN RESOURCES

**FOR EMPLOYMENT REASONABLE ACCOMMODATION REQUESTS ONLY**

Please provide the essential job function for the below named position.

Position Title:_______________________________________________________________

☐ Please attach the job description for this position

**Essential Job Functions for this position are:**

## SECTION III - TO BE COMPLETED BY PHYSICIAN

1. Does the applicant have a physical and/or mental impairment which will limit his/her ability to perform the essential functions of the activity(ies) mentioned in item C? __ Yes __ No

   If answered **YES,** to the above, please provide a description of the impairment and a diagnosis.

   ______________________________________________________________________

   ______________________________________________________________________

2. What limitation(s) does this impairment cause?

   ______________________________________________________________________

   ______________________________________________________________________

3. What is the expected duration of the impairment and the limitations?

   ______________________________________________________________________

   ______________________________________________________________________

   ______________________________________________________________________

4. Is the applicant capable of performing the essential functions of the activity with reasonable accommodations? __ Yes __ No

   If answered **YES**, to the above, please state the reasonable accommodations which are needed so the applicant can perform the essential functions of the activity(ies) mentioned in item C.

   ______________________________________________________________________

   ______________________________________________________________________

   ______________________________________________________________________

   ______________________________________________________________________

5. Please provide any additional information you believe is relevant to the applicant's impairment as it relates to his/her engaging in the activity(ies) mentioned in item C:

   ______________________________________________________________________

   ______________________________________________________________________

   ______________________________________________________________________

   ______________________________________________________________________

## PHYSICIAN/MEDICAL PROFESSIONAL INFORMATION:

Physician/Medical Professional Name (please print) ______________________________

Area of practice/specialty:______________________________

Address ______________________________

______________________________

Phone:______________________________ Fax:______________________________

Date ____________________Signature ______________________________

**Return Form To:**

Office of Equal Opportunity, 103 Wells Hall, Murray, KY 42071
Phone: (270) 809-3155 Fax: (270) 809-6887 TDD: (270) 809-6831