Accommodation Request: Employee's Serious Health Condition - Medical Form

Employee Completes This Section

I hereby authorize the below named health care provider to complete this form and disclose to Wayland Baptist University and its authorized representatives the following information related to my health care for the purposes of work place accommodations: diagnosis(es) of relevant conditions, ability to perform work, recommendations, and all other relevant documents.

_____	_____
Employee Name: Last, First and M.I.	Employee's Job Title
_____	_____
Name of Health Care Provider	Provider's Address
_____	_____

2. **Does the employee have a physical or mental impairment?** Yes / No

If *yes*, what is the impairment?

If *no*, skip to the signature line below and complete and return to Wayland Baptist University, Office of Human Resources

3. **What limitations are interfering with job performance, and how do they affect the employee's ability to perform the job function(s)?**

4. **What adjustments to the work environment or position responsibilities would enable the employee to perform the essential function(s) of that position?**

5. **The employee's typical schedule is_____. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position?**

6. **How would your suggestions improve the employee's essential functions of their t**