



CONFIDENTIAL
DURHAM REGIONAL HOSPITAL

Reasonable Accommodation Request Form - Employment

The purpose of this form is to assist the Duke University Health System/Durham Regional Hospital (DRH) in determining whether, or to what extent, a reasonable accommodation is required for a staff member with a disability to perform one or more essential functions of his or her job safely and effectively.

SECTION I: Staff Member/Applicant: To be completed by employee requesting accommodation.

Form with fields for Staff Member, Telephone, Address, Job Title, Request Date, Department Head/Supervisor, and a table for 'Have you contacted DRH Employee Health?' with Yes/No options and Date of Contact.

The accommodation requested is: _____

I, _____ give Duke University, including but not limited to, Durham Regional Employee Health, Disability Management System, HR, and my work unit, permission to explore possible coverage and reasonable accommodations under the Americans with Disabilities Act.

I further understand that I am required to complete and sign the attached release of information giving permission to consult with my health care professional(s) in order to determine that I am a qualified employee with a disability, to seek guidance as to any functional limitations resulting from my condition(s) and to assist the University in determining what appropriate accommodations may exist to address my limitations.

Date Staff Member's Signature

Please return this form and attached healthcare provider form to DRH Human Resources..



Duke University/Health System

Health Care Provider/Medical Information Release Form

I, _____, give Duke University/Health System
(employee)

permission to contact _____. I understand the reason for
(health care provider and/or Duke representative)

this contact is to explore my functional abilities and limitations in relation to a major life activity to assist the University in determining what appropriate accommodations may exist to address my limitations.

I understand that Duke will/may provide _____ with
(health care provider)

specific information about my job position, including the essential functions and specific requirements.

All information obtained from employee medical examinations and inquiries will be maintained and used in accordance with applicable confidentiality requirements.

Date: _____

Employee: _____

Witness: _____

Address of Healthcare Provider:

Phone Number:

Please return this form and attached RA request form to DRH Human Resources.

