



**Duke University/Health System**

Disability Management System, 402 Oregon Street, Suite 102, Box 90142, Telephone: (919) 668-6213, Fax: (919) 668-3977, <http://www.access.duke.edu>

**CONFIDENTIAL  
DUKE UNIVERSITY**

**Reasonable Accommodation Request Form – Employment**

The purpose of this form is to assist the Duke University/Duke University Health System in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of his or her job safely and effectively. This form must be filed separately from the employee's personnel file and be treated confidentially.

DUHS/College/School/Administrative Area	Department/Unit
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**SECTION I: Employee/Applicant: To be completed by employee requesting accommodation.**

Employee:	Telephone:		
Address:			
Job Title:	Date of Birth:		
Department Head/ Supervisor:	Telephone:		
Address:			
Human Resources Officer/Representative/Personnel Rep:	Telephone:		
Address:			
Have you contacted Employee Occupational Health and Wellness?	Yes	Date of Contact	No

The accommodation requested is: \_\_\_\_\_

I, \_\_\_\_\_ give Duke University, including but not limited to, EOHW, DMS, HR, E&O, FMD, Fire and Safety and my work unit, permission to explore possible coverage and reasonable accommodations under the Americans with Disabilities Act. I understand that all information obtained during this process will be maintained and used in accordance with applicable confidentiality requirements.

I further understand that I am required to complete and sign the attached release of information giving Duke permission to consult with my health care professional(s) as necessary 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 Employee's Signature

Please return this form and attached healthcare provider form to Disability Management System, 402 Oregon Street, Suite 102, Box 90142, Durham, NC 27708.

## HEALTH CARE PROVIDER MEDICAL INFORMATION REQUEST FORM

I \_\_\_\_\_, voluntarily give Duke University permission to contact

Dr. (s) \_\_\_\_\_,

Address \_\_\_\_\_, as necessary, for discussion of my case as it relates to possible limitations of a major life activity, which can affect my employment. I have been given an opportunity to ask questions regarding this form and to have those questions answered to my satisfaction. I further understand that all information obtained from this interaction will be maintained and used in accordance with applicable confidentiality requirement.

Requesting Provider: George Jackson, MD Phone Number: 684-3136

Address: P.O. Box 3148, DUMC, Durham, N.C. 27710

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

## ASSESSMENT AND REFERRAL FORM

If you are requesting possible coverage under the Americans with Disabilities Act (ADA) and associated reasonable accommodations or you are an individual with an impairment that may require evacuation assistance during an emergency, completion of this form will help assess your needs.

- **Employees** should return or fax the completed form along with the signed Reasonable Accommodation Request form and Health Care Provider Release form to the Disability Management System office at 402 Oregon Street, Box 90142, Fax: 668-3977.
- **Students** should contact the Disability Specialist at the Disability Management System-Student Access Office (SAO) to discuss and complete the form.

### General Information

Student Section	
Name:	Duke ID Number:
Address:	Email Address
Telephone Number:	College/School :
Residence Hall [Building/Room]:	
Employee Section	
Department/Unit:	Job Title:
Supervisor's Name:	Supervisor's Phone Number:
Work Location [Building/Room]:	

### DISABILITY

Visual     
  Hearing     
  Mobility     
  Other

Is the disability     
  Temporary (If so, how long? \_\_\_\_\_)     
  Permanent

*(Please complete **each** section that applies.)*

**Mobility:**

Does the impairment prohibit you from using steps or hinder their ability to negotiate stairs?

Yes     No. If yes, please describe:

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Do you have problem with different kinds of door hardware:( i.e. latches, knobs, panic hardware, or power assist buttons)?  Yes     No. If yes, please describe:

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During a normal day, if a fire alarm were to occur would you be able to evacuate the facility without assistance? \_\_\_Yes \_\_\_No

*For student residents only:* If they were fast a sleep in their room at night and a fire alarm occurred, would you be able to awake and evacuate without assistance? \_\_\_Yes \_\_\_No

**Hearing:**

Do you use hearing assistance devices during the day? \_\_\_Yes \_\_\_No. If yes, please describe:

\_\_\_\_\_

During a normal day, if a fire alarm were to occur would you be able to hear the alarm and evacuate without assistance or special notification? \_\_\_Yes \_\_\_No. If no, please describe the type(s) of assistance or notification that would be necessary:

\_\_\_\_\_

*For student residents only:* If you were fast a sleep in your room at night and a fire alarm occurred, would you be able to hear the signal to awake and evacuate without assistance or special notification? \_\_\_Yes \_\_\_No. If no, please describe the type(s) of assistance or notification that would be necessary:

\_\_\_\_\_

**Visual:**

Does your visual impairment prohibit or hinder their evacuation during an emergency? \_\_\_Yes \_\_\_No

Do you use a cane or guide dog that helps with travel throughout the day? \_\_\_Yes \_\_\_No. or exit a facility? \_\_\_Yes \_\_\_No. If yes, please describe:

\_\_\_\_\_

This form was completed by: \_\_\_\_\_

Date: \_\_\_\_\_

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*Note: The Disability Management System representative or the Student Access Office Disability Specialist should forward or fax the completed form to OESO-Fire Safety Division, 1411 Hull Street, Box 90427, Fax: (919) 684-5487.*

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**OCCUPATIONAL & ENVIRONMENTAL SAFETY OFFICE (OESO)**

Date form received from DMS or SAO \_\_\_\_\_.

Date facility was surveyed \_\_\_\_\_.

Date Site Specific Fire Plan was developed \_\_\_\_\_.

Date Training was conducted \_\_\_\_\_.

*Fire Safety Division personnel will return the completed form along with the site-specific fire plan to:*

***For Employees:*** Disability Management System, 402 Oregon Street, Box 90142 or Fax to (919) 668-3977.

***For Students:*** Disability Management System, Student Access Office (SAO), 402 Oregon Street, Box 90142 or Fax to (919) 668-3977.