LSU

Office of the ADA Coordinator

Employee Accommodation Request:

HEALTHCARE PROVIDER FORM

Section 1: TO BE COMPLETED BY EMPLOYEE

Employee Name:	**Employee's Email:**
Employee's Supervisor:	**Employee's Phone:**

Section 2. MEDICAL INFO: **TO BE COMPLETED BY HEALTHCARE**

The following questions may help determine whether an employee has a disability and what accommodation is needed to afford equal access.

History:

Does the employee have a disability that substantially limits a major life activity as compared to most people in the general population?

is the nature of the limitation(s)?

Diagnosis:

Subjective Symptoms:

When did the symptoms first appear (date and year)?
Date (MM, DD, YY) employee was last seen healthcare provider completing this form:
Date employee ceased work because of the disability (MM,DD,YY)
Has the employee ever had the same or similar condition?

What limitation(s) is interfering with job performance or

Is proposed accommodation temporary or permanent

|__| Temporary

|__| Permanent

If temporary, for how long?

How would your suggestions improve the employee's job performance?