Temporary Medical Accommodation Request Form

Instructions: Please fill out this form to request a temporary medical accommodation. Once completed, print this document and submit it to the appropriate department (Human Resources or Student Disability Services) along with any required medical documentation.

1. Requester Information

Full Name: _____

Employee or Student ID Number: _____

Email Address: _____

Phone Number: _____

Department, Job Title, or Major: _____

2. Medical Accommodation Details

Identify your temporary medical limitation(s) or barrier(s):

_____

Describe the specific temporary accommodation(s) you are requesting:

_____

Expected Start Date of Accommodation (MM/DD/YYYY): _____

Expected End Date of Accommodation (MM/DD/YYYY): _____

3. Healthcare Provider Information

Medical Provider Name: _____

Medical Specialty: _____

Provider Phone Number: _____

4. Acknowledgement and Signature

By signing below, I certify that the information provided on this form is true and accurate to the best of my knowledge. I understand that temporary accommodations are subject to review and may require formal medical verification.

Requester Signature (Sign after printing): _____

Date (MM/DD/YYYY): _____