University of Massachusetts Medical School
Accommodation Request Form

Employee Name: __________________________________________________________
Job Title: ________________________________________________________________
Department: ___________________________ Location: __________________________
Telephone Work: ______________________________ Telephone Home: __________
Emergency Contact Name: ______________________________ Telephone: __________
Supervisor’s Name: __________________________________ Telephone: __________

Please describe the nature of your disability: __________________________________
________________________________________________________________________
________________________________________________________________________

Accommodations you are requesting: _________________________________________
________________________________________________________________________
________________________________________________________________________

Should there be an emergency, will you need assistance?  □ YES  □ NO

You are required to provide medical documentation according to the attached guidelines.

I understand that submission of this form does not guarantee the accommodation(s) requested. I agree to work with the Diversity and Equal Opportunity Office to determine appropriate and reasonable accommodation(s) for my employment at UMMS. I grant permission to the Equal Opportunity Office to discuss my disability with my clinician, if needed.

Signed: ____________________________________________ Date: ________________

Please return this form to:
University of Massachusetts Medical School
Diversity and Equal Opportunity Office, S1-710
55 Lake Avenue North
Worcester, MA 01655
Telephone: 508-856-2179
Fax: 508-856-1810

To be completed by the Diversity and Equal Opportunity Office:

Final Accommodations Provided: ____________________________________________
________________________________________________________________________
Cost: ____________________________
Consult Conducted by: ________________________ Date: ________________
Guidelines for Medical Documentation

These guidelines are designed to assist your clinician in preparing documentation of your disability in order to help determine the appropriate accommodation. Please forward documentation that meets these guidelines to the Diversity and Equal Opportunity Office.

- Documentation must be provided by a clinician qualified to diagnose in the appropriate area of specialization.
- Documentation must be on letterhead, typed, dated, signed, and otherwise legible.
- Documentation is based on a current evaluation (usually within three months).
- Documentation must include:
  1. Clear support of the claimed disability with relevant medical and other history.
  2. A description of the functional limitations resulting from the disability.
  3. A description of current treatments and assistive devices and technologies with estimated effectiveness in ameliorating the impact of the disability.
  4. Clear support of the direct link to and need for the requested accommodation(s).

If you would like further information contact:

University of Massachusetts Medical School
Diversity and Equal Opportunity Office, S1-710
55 Lake Avenue North
Worcester, MA 01655
Telephone: 508-856-2179
Fax: 508-856-1810
Evacuation Plan for Individuals with Disabilities

Employee Name: ______________________________________________________________________
Telephone: _____________________________ Date: _____________________________
Department: _________________________________________________________________________
Supervisor’s Name: ___________________________ Telephone: __________________________

Hearing Impaired ☐ Vision Impaired ☐ Mobility Impaired ☐

Other (specify): _______________________________________________________________________

Location/Building: ___________________________ Room No: ________________

Exit Routes:
Primary: ____________________________________________________________________________
Secondary: ___________________________________________________________________________

Buddy(s):
1. Name: ____________________________________________________________________________
   Telephone: _________________________________________________________________________
2. Name: ____________________________________________________________________________
   Telephone: _________________________________________________________________________
3. Name: ____________________________________________________________________________
   Telephone: _________________________________________________________________________
4. Name: ____________________________________________________________________________
   Telephone: _________________________________________________________________________

Please check box if you do not require a plan ☐

Signatures:

Employee: __________________________________________ Date: ________________

Manager: __________________________________________ Date: ________________

Please return completed form to:
University of Massachusetts Medical School
Diversity and Equal Opportunity Office, S1-710
55 Lake Avenue North
Worcester, MA 01655
Telephone: 508-856-2467
Fax: 508-856-1810