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, H1-728
55 Lake Avenue North
Worcester, MA 01655
Telephone: 508-856-2179
Fax: 508-856-1810
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:
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Diversity and Equal Opportunity Office, H1-728
55 Lake Avenue North
Worcester, MA 01655
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Fax: 508-856-1810

To be completed by the Diversity and Equal Opportunity Office:

Final Accommodations Provided: __________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
Cost: ______________________
Consult Conducted by: ___________________________ Date: ____________________________
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, H1-728
55 Lake Avenue North
Worcester, MA 01655
Telephone: 508-856-2467
Fax: 508-856-1810