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:** ________________________

University of Massachusetts
UMASS Medical School

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