

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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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