

Accommodation Request Form

This is a confidential form and will be submitted by the requesting applicant/employee directly to Human Resources. Only employees are expected to complete workplace information.

Name: First (Given Name) Middle Lust (Family Name) Molden or other last name used Home/Cell Phone #: Office Phone: Department: Supervisor: Position: UIN: 2.) NATURE OF QUALIFYING DISABILITY 3.] REQUESTED/SUGGESTED ACCOMODATION Please describe the accommodations you believe are needed to enable you to perform the essential functions of this job. You may attach a separate sheet if necessary. 4.] PHYSICIAN CONTACT INFORMATION (Employees only) The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations. Physician Name: Name of Practice: Office Phone: Office Fax: Address Gity State Zip Code AUTHORIZATION and SIGNATURE Lauthorize the release of necessary confidential medical information regarding my disability to relevant hiring managers as deemed	1.) REQUESTOR INFORMATION	N						
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	necessary by Human Resources.	•	0 0 7	,				
Signature								
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Note to signatory:								
• In non-physician review cases, decisions regarding accommodations will be made within 10 days of the receipt of this form by Human								

Resources. Due to delays that may be caused in communications with physicians, no specific decision date can be provided for physician review cases.

If there are physical requirements are included in your position description you will be asked to review to ensure accuracy.

Questions: Contact Human Resources | 903-468-3021 | HR.Accomodations@tamuc.edu