Oklahoma Department of Corrections
Employee Request for Reasonable Accommodation

The following form will be used to determine whether an employee requires reasonable accommodation and what reasonable accommodation will be provided. If the employee's medical condition and need for reasonable accommodation are known, the form will be completed by the facility/unit without inquiry of a health care provider.

Employee's Name (PRINTED)	Job Title	Facility/Unit

I understand that I may be required to produce medical documentation of the claimed medical condition/disability at my own expense, and, under certain circumstances, required to be examined by a health care provider of the agency's choosing or have my medical documentation reviewed by the agency's health care provider, at the agency's expense. I hereby authorize the chief administrator of Human Resources or the chief medical officer to contact my health care provider for the purpose of clarifying or authenticating any information provided by my health care provider.

Employee Signature	Date
Received By	Date

Describe the Nature and Severity of Medical Condition/Disability or Impairment:

What is the Duration of Impairment (temporary or permanent, if temporary, for how long)?

List all restrictions and/or limitations to activity/activities:

List any essential job functions that cannot be performed due to the restrictions/limitations:

Describe the reasonable accommodation requested:

This completed form contains confidential medical information and must be maintained in the employee's medical file.

How does this reasonable accommodation enable the employee to perform the essential functions of the job?

Source of Information: □ Employee □ Health Care Provider

Health Care Provider (PRINTED) Area of Expertise/Specialty

Address Phone

Health Care Provider Signature Date

(01/22)

This completed form contains confidential medical information and must be maintained in the employee's medical file.