

Source of Information: Employee Health Care Provider

Health Care Provider (PRINTED)	Area of Expertise/Specialty
<hr/>	
Address	Phone
<hr/>	
Health Care Provider Signature	Date

To be Completed by Facility/District/Unit Head:

Request for Reasonable Accommodation:

- Approved Describe the reasonable accommodation provided: _____

- Denied Reason(s) for denial: _____

Facility/District/Unit Head Signature	Date
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(R 11/14)