To Vanderbilt Employee:

To initiate a request for a reasonable accommodation, an employee must:

- Submit the completed Reasonable Accommodation Request form and the Medical Information Request form to the Equal Opportunity, Affirmative Action and Disability Services Department (EAD).
- The Medical Information Request form is to be completed by the employee’s physician or care provider. Employees are to complete Section I below, provide a copy of their job description to their medical provider and have the medical provider complete Section II.
- Completed forms are to be returned to: Disability Services Director, PMB 401809, 2301 Vanderbilt Place, Nashville, TN 37240-1809 or faxed to: (615) 343-0671. For questions, please call (615) 322-4705.

Section I: To be completed by employee:

<table>
<thead>
<tr>
<th>Employee name</th>
<th>Job Title</th>
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Department

Supervisor

Release of Information

I hereby authorize the release of the following information to Vanderbilt for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Vanderbilt to seek clarification of this documentation if necessary by contacting my physician or care provider.

<table>
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<tr>
<th>Employee signature</th>
<th>Date</th>
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Section II: To be completed by the physician or care provider:

To Physician or Care Provider:

To initiate a request for reasonable accommodations, employees must provide current documentation of a disability. As the employee’s physician or care provider, you are asked to fully complete all sections of this form. Additional information can be attached if necessary. Note: Federal and state law define a disability as a physical or mental impairment that substantially limits one or more major life activities, an individual having a record of such an impairment, or an individual being regarded as having such an impairment.

To complete this form (see attached, page 2, section 2), you should review the employee’s job functions and other information relevant to the employee’s job at Vanderbilt. If those materials have not been provided, please contact the employee and let him or her know you cannot complete this form without those materials.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual’s family medical history, the results of an
individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Thank you for your assistance.

1. Please identify the employee’s physical or mental impairment:

________________________________________________________________________

________________________________________________________________________

2. Please describe the effects or limitations (e.g., long-term, permanent, recent, short-term).

________________________________________________________________________

3. Please describe the effects or limitations this impairment has on the employee’s activities, if any:

________________________________________________________________________

________________________________________________________________________

4. By reviewing the attached information concerning the employee’s job duties, please describe the effect or limitations the impairment has on the employee’s ability to perform the job duties, if any:

________________________________________________________________________

________________________________________________________________________

5. Are there any activities or situations that should be avoided or that would present a health or safety risk to the employee or others due to the impairment?

________________________________________________________________________

6. Please offer any suggested accommodations that might enable the employee to perform his or her job duties:

   ● ___________________________________________ Duration? ___________________
   
   ● ___________________________________________ Duration? ___________________
   
   ● ___________________________________________ Duration? ___________________

Thank you for your assistance in providing this information so that we may assess the employee’s request. Please sign below.

Signature of physician or care provider __________________________ Date ____________

Provider name (printed) __________________________ Telephone # __________________________

Last updated 6/2/2011
Equal Opportunity, Affirmative Action and Disability Services Program

Reasonable Accommodation Request Form
for Vanderbilt Employees

In keeping with local, state and federal laws, Vanderbilt provides reasonable accommodations to qualified employees with disabilities. In general, it is the employee’s responsibility to inform his/her supervisor that he/she needs a disability related accommodation in order to perform the essential functions of the job. A supervisor is not required to provide reasonable accommodations if he/she is not aware of the employee’s need and desire for the accommodation. Reasonable accommodations are determined, identified and implemented in a collaborative process among the employee, supervisor and the Equal Opportunity, Affirmative Action and Disability Services (EAD’s) Disability Services Director.

Contents of this request are confidential and will only be shared as needed with the appropriate personnel to consider the implementation of a reasonable accommodation. This form will not be placed in your employment record file. All medical documentation will be kept confidential. To help initiate your request, complete both forms and forward your supporting medical documentation to the EAD’s Disability Services Director, PMB 401, 809, 2301 Vanderbilt Place, Nashville, TN 37240-1809 or fax to (615) 343-0671.

Today’s Date: _____________________ Employee ID# _______________ E Mail: __________________________

Name: ____________________________ Job Title/ Dept: ____________________________

Immediate Supervisor: ____________________________ Supervisor’s phone #: ____________________________

Employee Relations Representative: ____________________________

(Please note that while your supervisor will be involved in the process, information about your medical condition, including medical documentation, will not be shared, unless authorized by you.)

Home Address: __________________________________________

(Number & Street) __________________________________________

(City) ____________________________ (State) _______________ (Zip) _______________

Email: ____________________________ Work Phone: ____________________________ Home Phone: ____________________________

How would you like for our office to contact you? E mail [ ] Work Phone [ ] Home Phone [ ]

Please provide a brief description of your job responsibilities. If you have a current job description, please provide a copy with this request.

Please explain aspects of your employment responsibilities that are impacted by your condition and how they are impacted. (Use the back of this form for more space.)
Information About Your Accommodation Request

1. What is the medical diagnosis for which you are requesting the accommodation?

2. Does your condition limit any major life activity? If so, please explain which life activity/activities is/are affected.

3. Is your condition temporary or permanent? If temporary, please indicate the duration of the condition.

4. Please list the reasonable accommodation(s) that you are requesting.

5. What other accommodations might be responsive to your request?

6. How long do you anticipate the need for an accommodation?

7. Explain how the requested accommodation will enable you to perform the essential functions of your job.

Please check appropriate box:

Are you currently participating in the Return to Work program? Yes [ ] No [ ]

Have you been approved for FMLA? Yes [ ] No [ ]

Have you requested a reasonable accommodation through this office or any other office before? Yes [ ] No [ ]

If ‘Yes’, is it the same condition or impairment that you are currently requesting an accommodation for? Yes [ ] No [ ]

If ‘Yes’, approximately when was the request made? ____________________________

This is to acknowledge that I am requesting a reasonable accommodation. I agree to fully cooperate with the EAD’s Disability Services Department in responding to my request, including providing the appropriate medical documentation. I understand that I may not be provided with the specific accommodation that I have requested; however, I understand that good faith efforts will be made in making a determination. I verify that the above information is complete and accurate to the best of my knowledge.

Signature: ____________________________________________ Date: ______________________________

Last Updated 2/22/10