SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

Accessible Campus Community &
Equitable Student Support (ACCESS)

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a Student Success Center, Room 1203, Campus Box 1611, Edwardsville, Illinois 62026-1611

Medical Release / Accommodation Verification Form

Employee Information

Employee's Name: _____

800#: _____ Date: _____

I authorize Accessible Campus Community & Equitable Student Support (ACCESS) at SIUE to release and/or receive information from the provider below. I also authorize my provider to discuss my condition(s) with the ACCESS office for the purposes of approving a workplace accommodation:

Employee Signature: _____

Provider Information

Name of Provider: _____

License #: _____ State: _____

Address: _____

_____

Phone #: _____ Fax #: _____

*To determine eligibility for workplace accommodations, Southern Illinois University Edwardsville (SIUE) requires current and comprehensive information on the employee's condition from the diagnosing physician or health care provider (the provider completing this form should **not** be a relative of the employee).*

Information about the Employee's Disability *(A person with a disability is defined as someone who has "a physical or mental impairment that substantially limits one or more major life activities.")*

1. **For what condition are you treating the above referenced employee?**

   a. **How long has the employee had this condition?**
   b. **What is the severity of the condition? (Please Check One) ◯ Mild ◯ Moderate ◯ Severe**
   c. **What is the expected duration of this condition?**

2. **Please state the following:**
   a. **Date of first contact with employee**
   b. **Date of last contact with employee**
   c. **Frequency of appointments with employee**

3. **List the employee's current medication(s), dosage, frequency, and adverse side effects, as they may relate to the employee's need for accommodation(s):**

4. **Describe the functional limitations of the employee's condition as it relates to employment:**
   a. **Is the requested accommodation: ☐ Medically Necessary ☐ Medically Beneficial (please check one and explain response below):**

5. **Please state specific recommendations regarding workplace accommodations for this employee. Include a rationale as to why these accommodations are warranted based upon the employee's functional limitations. Indicate why the accommodation(s) are necessary (i.e. if you suggest a remote work accommodation, please state the reasons for this request related to the employee's functional limitations and disability).**

Medical Provider's Signature **Date**

Upon completion, please return to ACCESS office at Southern Illinois University Edwardsville by email or fax.