

REQUESTING REASONABLE ACCOMMODATION & AUTHORIZATION TO OBTAIN

The purpose of this form is to assist Louisiana State University Office of Human Resource Management in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform the essential functions of their job safely and effectively. This form must be completed by the employee requesting an accommodation.

EMPLOYEE INFORMATION		
Employee:	Email:	
Job Title:	Telephone:	
Employee's Supervisor:	Department:	
STEPS NEEDED TO IMPLEMENT		
Will this accommodation or disability be temporary or permanent?	Temporary <input type="checkbox"/>	Permanent <input type="checkbox"/>
If temporary, what is anticipated duration?		
Is equipment needed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe in detail:		
Is a classroom reassignment requested?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, indicate current course number(s) and section(s), current classroom location(s), and future preferred classroom location(s). Please behind the rationale behind preferred classroom location(s).		
What other accommodations are requested?		
AUTHORIZATION TO OBTAIN INFORMATION		
I authorize my healthcare provider to give LSU's Office of Human Resource Management or its agents any and all information pertaining to diagnosis, treatment, and prognosis.		
I understand the information obtained by use of the Authorization will be used by LSU to determine the nature and scope of accommodating my position for modified duty or FMLA purposes. Any information obtained will not be released by Human Resource Management to any person except to University agents.		
I know that I may request to receive a copy of this Authorization.		
I agree that a photographic copy of this Authorization shall be valid as the original.		
SIGNATURE		
Employee:	Date:	