

**REASONABLE ACCOMMODATION FORM**  
Application for FACULTY or STAFF with a Disability



**SECTION III TO BE COMPLETED BY MEDICAL PROVIDER**

1. Does the applicant have a physical and/or mental impairment which will limit his/her ability to perform the essential functions of the activity(ies) mentioned in item C?  Yes  No

If answered YES, to the above, please provide a description of the impairment and a diagnosis.

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2. What limitation(s) does this impairment cause? \_\_\_\_\_

3. What is the expected duration of the impairment and the limitations? \_\_\_\_\_

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4. Is the applicant capable of performing the essential functions of the activity with reasonable accommodations?  Yes  No

If answered YES, to the above, please state the reasonable accommodations which are needed so the applicant can perform the essential functions of the activity(ies) mentioned in item C. \_\_\_\_\_

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relates to his/her engaging in the activity(ies) mentioned in item C: \_\_\_\_\_

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Physician/Medical Professional/ARPN Name (please print) \_\_\_\_\_

Area of practice/specialty: \_\_\_\_\_

Address \_\_\_\_\_

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Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Return Form To:  
The Office of Institutional Diversity, Equity and Access  
103 Wells Hall  
Murray, KY 42071  
Phone: (270) 809-3155 Fax: (270) 809-6887 TDD: (270) 809-6831

## APPEALS PROCESS

Any person seeking to appeal the decision must submit, in writing, a request to review the decision. This appeal must be delivered to the Office of Institutional Diversity, Equity and Access, within five (5) working days of receipt of the Executive Director's decision. The request shall state reasons why the party is requesting a review and may contain any information for consideration. The appeal will be referred to the Affirmative Action Subcommittee on Disabilities. The committee may confirm, amend, or modify the decision. The decision of the committee shall be final.