Disability Management Systems
402 Oregon Street, Suite 102, Box 90142, Durham, NC 27708, Telephone: (919) 684-8247, Fax: (919) 668-3977, TTY: (919) 668-1329
http://www.access.duke.edu

CONFIDENTIAL
DUKE REGIONAL HOSPITAL

Reasonable Accommodation Request Form - Employment

The purpose of this form is to assist the Duke University Health System/Duke Regional Hospital (DRH) in determining whether, or to what extent, a reasonable accommodation is required for a staff member with a disability to perform one or more essential functions of his/her job safely and effectively. This form must be filed separately from the staff member's personnel file and be treated confidentially. Please complete this form in its entirety.

SECTION I: Employee/Applicant: To be completed by employee requesting accommodation.

Employee:	Department/Unit (Ex. Pediatric/Cardiology):		
Work Address and Email Address:	Telephone:		
Home Address and Personal Address:	Duke Unique ID:		
Job Title:	Request Date:		
Department Head/ Supervisor:	Telephone:		
Address:			
Have you contacted DRH Employee Health? /EOHW?	Yes	Date of Contact	No

The accommodation requested is: _____

I,_____ give Duke University, including but not limited to, EOHW, DRH Human Resources, Disability Management System, and my work unit, permission to explore possible coverage and reasonable accommodations under the Americans with Disabilities Act and the ADA Amendments Act. I understand that all information obtained during this process will be maintained and used in accordance with applicable confidentiality requirements.

I further understand that I am required to submit pertinent documentation from my healthcare provider(s) regarding my impairment(s). In addition, I have completed and signed the attached release of information giving permission to consult with my health care professional(s) as necessary to determine that I am a qualified employee with a disability, to seek guidance as to any functional limitations resulting from my condition(s) and to assist the University in determining what appropriate accommodations may exist to address my limitations.

Date Staff Member's Signature

Please return this form, attached health care provider request and Referral form to DMS via fax (919) 668-3977, email dukedms@duke.edu or mail to PO Box 90142, Durham, NC 27708.

Modified 11/25/14

HEALTH CARE PROVIDER MEDICAL INFORMATION
REQUEST FORM

I_____, voluntarily give Duke University permission to contact

Dr. (s) _____,

Address_____, as necessary, for discussion of my case as it relates to possible limitations of a major life activity, which can affect my employment. I have been given an opportunity to ask questions regarding this form and to have those questions answered to my satisfaction. I further understand that all information obtained from this interaction will be maintained and used in accordance with applicable confidentiality requirement.

Requesting Provider: Carol Epling, MD or Associates

Phone Number: 684-3136

Address: P.O. Box 3148, DUMC, Durham, N.C. 27710

Employee Signature: _____

Date: _____

Witness: _____

Please return this form to DRH Human Resources

FIRE SAFETY REFERRAL FORM

IMPORTANT NOTE:
PLEASE COMPLETE ALL APPLICABLE SECTIONS BELOW AS THIS FORM WILL BE SENT TO THE FIRE SAFETY OFFICE FOR FOLLOW-UP.

Employees and Students Must Complete the Following 6 Sections:		
Name:	Duke Unique ID Number:	Telephone Number:
Address (Office or Residence Hall – Building & Room Number):	School/College/Administrative Unit:	Email Address:

Employees Must Complete the Following Additional 4 Sections:			
Department/Unit:	Job Title:	Supervisor's Name:	Supervisor's Phone Number:

We are asking all employees and students to identify any medical limitations they have that may interfere with emergency evacuation. We are collecting this information to help us effectively develop an emergency evacuation plan. Self-identification is voluntary and the information you provide will be kept confidential and shared only with those who have responsibilities under the emergency evacuation plan.	
Do you have limitations that may interfere with your ability to evacuate during an emergency? --- If yes, what are they?	Yes ☐ No ☐
Do you need assistance for emergency evacuation? --- If yes, what type of assistance do you need?	Yes ☐ No ☐
In the event of an emergency, will you need any special medication, equipment, or device (e.g., a mask because of a respiratory impairment, an evacuation device because you cannot climb or descend stairs, etc.)? --- If yes, what will you need?	Yes ☐ No ☐

If additional information is needed, we will contact you as soon as possible. If you have any questions, please let us know.
This form was completed by: _____ ***Date:*** _____

- ***Employees*** *should return or fax the completed form along with the signed Reasonable Accommodation Request form and Health Care Provider Release form to the Disability Management System office at 402 Oregon Street, Box 90142, Fax: 668-3977.*
- ***Students*** should contact the Disability Coordinator at the Disability Management System-Student Disability Access Office (SDAO) to discuss and complete the form.

Modified 11/25/14

Note: The Disability Management System representative or the Student Disability Access Office Coordinator will forward or fax the completed form to OESO-Fire Safety Division, 1411 Hull Street, Box 90427, Fax: (919) 684-5487.

OCCUPATIONAL & ENVIRONMENTAL SAFETY OFFICE (OESO)

Date form received from DMS or SDAO_____.
Date facility surveyed _____.
Date Site Specific Fire Plan developed _____.
Date Training conducted _____.

Fire Safety Division personnel will return the completed form along with the site-specific fire plan to:
***For Employees**: Disability Management System, 402 Oregon Street, Box 90142 or Fax to (919) 668-3977.*
***For Students**: Disability Management System, Student Disability Access Office (SDAO), 402 Oregon Street, Box 90142 or Fax to (919) 668-3977.*