SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

ACCESS Workplace Accommodation/Medical Release Form

Section 1: Employee Information and Authorization

Employee 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 purpose of approving a workplace accommodation:

Employee Signature: _____

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

Section 2: Licensed Provider Information

Name of Provider: _____

Title: _____

Phone Number: _____

License/Certification Number: _____

I certify that the information below is true and accurate.

Signature: _____

Practice Name and Address (Stamps Welcome)

*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.")*

For what condition(s) are you treating the above referenced employee?

How long has the employee had this diagnosis/condition? _____

What is the severity of the condition? (Please Check One): ☐ Mild ☐ Moderate ☐ Severe

What is the expected duration of this condition? _____

Accessible Campus Community & Equitable Student Support (ACCESS)
t 618.650.3726 **w** siue.edu/access
a Student Success Center, Room 1203, Campus Box 1611, Edwardsville, IL 62026-1611

Please state the following:

Date of first contact with employee: _____

Date of last contact with employee: _____

Frequency of appointments with employee: _____

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):

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

Please state specific recommendations regarding workplace accommodation(s) 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 remote or hybrid work accommodation, please state the reasons for this request related to the employee's functional limitations and disability):

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