

# Employee Accommodation Request Form



**Attention Employee:** Please complete this form and return by email to [LSC-EmployeeAccommodations@lonestar.edu](mailto:LSC-EmployeeAccommodations@lonestar.edu), by fax to (832) 246-0059, or by hand delivery to the Compliance Education & Training Department if you are requesting reasonable accommodation(s) based on disability.

<b>Employee Name:</b>	<b>Employee ID:</b>	<b>Date:</b>
<b>Supervisor Name:</b>	<b>Department:</b>	

**Location:** Please check next to your work location below.

<b>Campuses:</b>	<b>Centers:</b>	<b>Additional Locations:</b>
<input type="checkbox"/> LSC-CyFair	<input type="checkbox"/> LSC-Atascocita	<input type="checkbox"/> LSC-Health Professions Building
<input type="checkbox"/> LSC-Kingwood	<input type="checkbox"/> LSC-Conroe	<input type="checkbox"/> LSC-Tomball Health Science Building
<input type="checkbox"/> LSC-Montgomery	<input type="checkbox"/> LSC-Creekside	<input type="checkbox"/> LSC-Transportation Institute
<input type="checkbox"/> LSC-North Harris	<input type="checkbox"/> LSC-Cypress	<input type="checkbox"/> LSC-CHI Institute
<input type="checkbox"/> LSC-Tomball	<input type="checkbox"/> LSC-EMCID	<input type="checkbox"/> LSC-Energy & Manufacturing Institute
<input type="checkbox"/> LSC-University Park	<input type="checkbox"/> LSC-Fairbanks	<input type="checkbox"/> LSC-Process Technology Center
<input type="checkbox"/> LSC-Houston North	<input type="checkbox"/> LSC-Greenspoint	<input type="checkbox"/> LSC-System Office, The Woodlands
	<input type="checkbox"/> LSC-Process Technology	<input type="checkbox"/> LSC-System Office, University Park
	<input type="checkbox"/> LSC-Victory	<input type="checkbox"/> Other _____
	<input type="checkbox"/> LSC-Westway Park Technology	_____

**Employee Information:** (use additional pages as needed)

Please state your Disability, Impairment, or Condition. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe how your condition limits your ability to perform your essential job functions.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe the specific accommodation(s) you are requesting. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe how the accommodation(s) will enable you to perform your essential job functions. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please indicate the expected duration of the impairment(s).**

Permanent       Temporary – Anticipated End Date: \_\_\_\_\_

**Verification Documentation:**

- I have included current documentation from a licensed or certified professional qualified to treat and diagnosis my disability, impairment, or condition.
- Current documentation is not attached.

**NOTE:** As a part of the accommodation process, the Executive Director of Compliance Education and Training may need you to obtain additional information. The College reserves the right to request health care provider documentation to verify the existence of a disability, impairment, or condition to appropriately assess your functional limitations as they relate to your reasonable accommodation request and essential job functions. You will be notified and your permission obtained if this is necessary.

All information obtained during this process will be maintained and used in accordance with disability law and College privacy requirements.

# Employee Disability Verification Form



**Attention Licensed or Certified Health Care Provider:** Please complete this form and send to [LSC-EmployeeAccommodations@lonestar.edu](mailto:LSC-EmployeeAccommodations@lonestar.edu) or fax to (832) 246-0059. Please call (832) 813-6614 if you have any questions.

**NOTE:** The College may only accept disability verification from a licensed or certified health care provider qualified to treat and diagnose the employee's disability. The information sought on this form pertains only to the disability for which the employee is requesting accommodation under applicable laws. In addition, if questions arise about the documentation provided, the Executive Director of Compliance Education and Training may contact the provider for clarification.

<b>Employee Name:</b>			
<b>Provider Name:</b>	<b>Specialization/Type of Practice:</b>		
<b>Provider's Practice Name &amp; Address:</b>	<b>Provider Phone No.:</b>		
<b>Provider Questions.</b> A person has a qualifying disability under applicable law if the person has an impairment that substantially limits one or more major life activities.			
1. Does the employee have a physical or mental impairment?      Yes <input type="checkbox"/> No <input type="checkbox"/>			
2. What is the impairment? _____			
3. Is the impairment permanent?      Yes <input type="checkbox"/> No <input type="checkbox"/>			
4. If <u>not</u> permanent, how long will the impairment likely last? _____			
5. Does the impairment mean that the employee is substantially limited in a major life activity?      Yes <input type="checkbox"/> No <input type="checkbox"/>			
6. If you checked "yes" on No. 5, what major life activity is affected (select all that apply):			
<input type="checkbox"/> self-care	<input type="checkbox"/> walking	<input type="checkbox"/> hearing	<input type="checkbox"/> interacting with others
<input type="checkbox"/> lifting	<input type="checkbox"/> standing	<input type="checkbox"/> seeing	<input type="checkbox"/> performing manual tasks
<input type="checkbox"/> sleeping	<input type="checkbox"/> reaching	<input type="checkbox"/> speaking	<input type="checkbox"/> concentrating
<input type="checkbox"/> breathing	<input type="checkbox"/> thinking	<input type="checkbox"/> learning	<input type="checkbox"/> reproduction
<input type="checkbox"/> toileting	<input type="checkbox"/> sitting	<input type="checkbox"/> working	
<input type="checkbox"/> other: _____			

**Provider Accommodation Recommendations.**

Do you have any suggestions regarding possible accommodations? If so, what are they?

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**Additional Comments:**

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**PROVIDER SIGNATURE:**  
(Stamps or Designee Signatures are **NOT** accepted)

**Date:**

**GINA NOTICE:** (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.