

Temporary Medical Condition Accommodation Request Form

Personal Information

Full Name

Email Address

Phone Number

Department/Unit

Job Title/Position

Medical Condition Details

Temporary Medical Condition (briefly describe)

Condition Onset Date

Expected Duration of Condition

Accommodation Request

Requested Accommodation(s)

Work Duties Impacted

Additional Information (if any)

Medical Provider Information (if applicable)

Provider's Name

Provider's Contact Information

Supporting Documentation Provided

Declaration

Signature

Date