Employee Chronic Illness Accommodation Request Form

Employee Information

Full Name

Employee ID

Department

Position/Title

Contact Information

Medical Information

Chronic Illness/Condition

How does this condition impact your ability to perform your job?

Accommodation Request

Describe the specific accommodation(s) you are requesting

Expected duration of accommodation

Additional Comments or Information

Healthcare Provider Information (if applicable)

Healthcare Provider Name

Healthcare Provider Contact

Have you attached supporting medical documentation?

Employee Signature

Signature

Date