

**EMPLOYEE'S REQUEST FOR  
A TEMPORARY JOB MODIFICATION DUE TO A MEDICAL CONDITION**

---

Name of employee requesting job modification: \_\_\_\_\_ Person No. \_\_\_\_\_  
Department \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

---

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

---

Period that job modification is being requested: \_\_\_\_\_ day(s)    week(s)    month(s)

What part of the required job duties are you unable to perform or what part of the work environment are you unable to tolerate because of your medical condition: \_\_\_\_\_  
\_\_\_\_\_

What type of job modification are you requesting? (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Schedule Change             | <input type="checkbox"/> Modification of work site environment                  |
| <input type="checkbox"/> Modification of duties      | <input type="checkbox"/> Reassign to different responsibilities (Employee Only) |
| <input type="checkbox"/> Special Equipment or Device | <input type="checkbox"/> Other _____  |

Describe this job modification and explain how it will allow job duties to be performed:  
\_\_\_\_\_  
\_\_\_\_\_

Return to Work Certification to support the need for job modification is attached:    Yes    No

**Requests greater than seven (7) days will only be considered with completed Physician's Work Certification.**

---

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---

The above-described job modification is acceptable to the department:    Yes     Further Review Requested

Department Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone number where dept. representative can be reached: \_\_\_\_\_

---

**FINAL APPROVAL IS SUBJECT TO INSTITUTIONAL REVIEW.**

**RETURN THIS FORM TO:**

Return To Work Coordinator  
Route: 0818  
Fax: 409 772-0951  
Phone: 409 772-1896

---