Temporary Accommodation

Date:

Name:

Phone number:

Re: Temporary accommodation

We have received medical documentation from your physician, _____, dated _____.

This documentation lists the following medical restrictions:
_____
_____
_____

Your department is able to provide you with a temporary accommodation for the following period of time:

Assignment beginning on _____ and ending on _____.

The description of this temporary modification to your position or alternate position is:
(*Include description of accommodation here*)

This is a temporary accommodation, not a permanent position. It is designed to assist you while you are recovering. At the end of this specific period of time, you will need to provide a medical update indicating either a release to perform the essential functions of your position or information describing updated functional limitations, so that a determination can be made regarding continuation of the temporary accommodation.

The employee understands the obligation to do the following:

- Work within the written medical limitations.
- Provide medical updates of functional limitations.

Any extension of this accommodation beyond the above specified time will be decided on a case by case basis. This will be dependent upon, among other factors, department operational needs, and upon updated information from your physician.

This temporary accommodation will be reviewed on: _____.

_____ _____
Employee Date

_____ _____
Supervisor Date

cc: Disability Management Services