Employee Temperature Modification Form

(To be completed by the employee)

Date _____

Employee Name____________________________ Department ____________ Division_________

Building Address____ Phone Number________________

Supervisor Name___________________ Phone Number____________

Employee: Please provide in detail all of the below-requested information. If you need additional space, please use the reverse side of each page and/or attach additional pages.

1. What are the current diagnoses of your relevant mental or physical health conditions? (Please only disclose conditions for which you may need a modification)
   ____
   ____
   ____

2. Please detail the extent (nature, frequency, severity and duration) of symptoms or difficulty relative to performing your work tasks.
   ____
   ____
   ____

3. Please identify and describe any special equipment, methods, skills, procedures or adjustments that may enhance your abilities to perform one or more of the essential functions of your job.

   ____
   ____
   ____

Date: ______________

Employee's Signature: ______________________________________

Health Care Provider Statement Employee Temperature Modification Form

(To be completed by the Healthcare Provider)

Date _____

Employee Name ___________________________

Healthcare Provider: Please provide in detail all of the below-requested information. If you need additional space, please use the reverse side of each page and/or attach additional pages.

1. What are the current diagnoses of the relevant mental or physical health conditions? (Please only disclose conditions for which the employee needs a modification)
   ____
   ____
   ____
   ____
   ____

2. Please detail the extent (nature, frequency, severity and duration) of symptoms or difficulty the employee experiences when performing their work tasks.

   ____
   ____
   ____
   ____

3. Please identify the ideal temperature range for your patient and potential workplace modifications in order of effectiveness (OR go to question 4 below) : Temperature Min _____ Max _____

Rank	Type of Modification	Specific Example(s)	How Modification Will Benefit Employee
	Work station changes or redirecting vents		
	Use of cooling or heating vest or other clothing		
	Reduce or increase work-site temperature		
	Use of fan or heater at the workstation (indicate desired temperature range)		
	Allow flexible scheduling		

4. Please identify and describe any additional special equipment, methods, skills, procedures or adjustments that may enhance the employee's abilities to perform one or more of the essential functions of the employee's job. Temperature Min _____ Max _____
   ____
   ____
   ____
   ____

If you have any questions, please contact ___________ at (   ) _________ or ___________@utah.gov.

Thank you,

Physician Signature__________________________________ Date_________________

Employee Temperature Modification Form

(To be completed by the ADA Coordinator)

For Internal Use Only

Needs further ADA Consideration? **Yes** **No**

If no, Self Assessment Sent

- Number of Windows in Area? _________ Date Evaluated _________
- Workspace Near Door/Exit? _________ Date Evaluated _________
- Alternate Space Available? _________ Date Evaluated _________
- Space Heaters in Area? _________ Date Evaluated _________
- Individual Temp Control in Area? _________ Date Evaluated _________

Referred to Risk Manager or Support Services Personnel Date: _______

Equipment Ordered Date: _______

Equipment Delivered Date: _______

(If appropriate) “Modifications are issued without ADA consideration” letter Date: _______

If yes, additional medical information necessary? **Yes** **No**

ADA Forms Necessary? Yes No Date ______________

Accommodations Approved? **Yes** **No**

Accommodation Granted Letter sent? **Yes** **No** Date: ________

Equipment Ordered Date: _______

Equipment Delivered Date: _______

Accommodations Granted Letter Date: _______

______________________________________ Date: _____________________________

ADA Coordinator

Employee Temperature Modification Form

Medical Documentation Supports the Requested Temperature Modification: Yes No

Rank	Type of Modification	Specific examples	How Modification Will Benefit Employee
1			
2			
3			
4			
5			

Additional Notes:____
____
____

Please note:

As a service organization DFCM would like to always be able to meet tenant's requests. However, DFCM has to weigh each request with its effect on other individuals in the building, the effect on acceptable lighting levels for building vs. programmed needs, consider whether it affects existing building systems, or the efficiency of the building, and any funding concerns there may be. These considerations will be evaluated per DFCM Policy 63-11.0. DFCM would ask that requesting employees be aware of these critical factors in this decision. In addition, DHRM staff alert DFCM staff in the event a direct threat[1] exists and further consideration is necessary.

Thank you.

FOR DFCM USE:

Approved (Date)__________ with ( ) No Changes ( ) Changes Requested as Explained Below:
Denied and Returned to Agency ADA Coordinator for Reasons Noted Below Date ________

DFCM Employee Signature __________________ Date __________

[1] The ADAAA states that a direct threat as "a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation."