FIU FLORIDA INTERNATIONAL UNIVERSITY
Division of Human Resources

EQUAL OPPORTUNITY PROGRAMS & DIVERSITY
PHYSICIAN'S VERIFICATION OF ACCOMMODATION

Please print legibly or type.

Employee/Patient Name: _____

Diagnosis: _____

Date initially diagnosed: _____ Probable duration of condition: _____

Recommended accommodation(s): _____

_____

Prescribed treatment regimen (Please indicate general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment and whether or not it is medically necessary for the employee to miss work on an intermittent basis or to work less than the employee's normal scheduled hours per day or days per week.):

Treatment by physician/practitioner: _____

_____

_____

_____

_____

Treatment by physician referred health services provider: _____

_____

_____

_____

_____

Physician's/Practitioner's Name (please print): _____

Type of practice (field of specification, if any): _____

Florida Board of Medical Examiners license number: _____

Address: _____

Telephone number: _____ Web Address: _____

Physician Signature: _____ Date: _____

Please submit completed form to:
Equal Opportunity Programs & Diversity
Florida International University
11200 SW 8th Street, PC 215
Miami, Florida 33199