

# Employee Ceiling Light 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. If you know, what are the current diagnoses of your relevant mental or physical health conditions? (Please only disclose conditions for which you may need a modification)

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2. Please *detail* how and to what extent (nature, frequency, severity and duration) of difficulty or symptoms when you perform each Activity.

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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.

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Date: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_

# Health Care Provider Statement Employee Lighting 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. If you know, what are the current diagnoses of your relevant mental or physical health conditions? (Please only disclose conditions for which the employee needs a modification)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please *detail* how and to what extent (nature, frequency, severity and duration) of difficulty or symptoms the employee experiences when performing each Activity.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Please identify in order of effectiveness which modification will be most beneficial.

Type of Lighting	Specific Replacement	Rank	Reduces Symptom	Benefit
Incandescent Lighting				
Wattage Change + or -				
Color of Bulb/Filter				
Natural				
Full Spectrum				

4. Please identify and describe any 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have any questions, please contact **(Name)** at **(Number)** **(e-mail)**.

Thank you,

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Address \_\_\_\_\_



## Employee Lighting Modification Form

(For DFCM Use Only)

**Medical Documentation Received Supports the Requested Lighting Modification: Yes No**

Type of Lighting	Specific Replacement	Rank	Reduces Symptom	Benefit
Incandescent Lighting				
Wattage Change + or -				
Color of Bulb/Filter				
Natural				
Full Spectrum				

- Number of Lights in area \_\_\_\_\_ Date Modified \_\_\_\_\_
- Wattage of Bulbs \_\_\_\_\_ Date Modified \_\_\_\_\_
- Number of Windows \_\_\_\_\_ Date Modified \_\_\_\_\_
- Color /Filter \_\_\_\_\_ Date Modified \_\_\_\_\_
- Ballast Adjustment \_\_\_\_\_ Date Modified \_\_\_\_\_
- Full Spectrum \_\_\_\_\_ Date Modified \_\_\_\_\_

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 affect on other individuals in the building, the affect 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. DFCM would ask that requesting employees be aware of these critical factors in this decision.

Thank you.