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)
   _____
   _____
   _____

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

   _____
   _____
   _____

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 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

(To be completed by the ADA Coordinator)

For Internal Use Only

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

If no, Self Assessment Sent

- o Monitor Placement _____ Date Evaluated _____
- o Number of Lights in area _____ Date Evaluated _____
- o Number of Windows _____ Date Evaluated _____
- o Computer Monitor placement _____ Date Evaluated _____
- o Wattage of Bulbs _____ Date Evaluated _____
- o Alternate Space Available _____ Date Evaluated _____

Referred to Risk Manager or Support Services Personnel Date: _____

Equipment Ordered Date: _____

Equipment Delivered Date: _____

Letter modifications are issued without ADA consideration. 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 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				

- o Number of Lights in area _____ Date Modified _____
- o Wattage of Bulbs _____ Date Modified _____
- o Number of Windows _____ Date Modified _____
- o Color /Filter _____ Date Modified _____
- o Ballast Adjustment _____ Date Modified _____
- o 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.