

## Documentation of Disability Form

### Employee Section

To initiate a request for accommodation, please complete the Accommodation Request Form, and have your physician or medical provider complete this form. Sign the *Release of Information* below. Questions may be directed to the Director of Employee Relations/ADA Coordinator at (828) 251-6605. Your physician or medical provider should send this completed form to:

Director of Employee Relations / ADA Coordinator  
The University of North Carolina at Asheville  
Phillips Hall, CPO #1450  
One University Heights  
Asheville, NC 28804-8503

### **Release of Information:**

I, \_\_\_\_\_ (*print name*), hereby authorize the release of the following information to The University of North Carolina at Asheville for the purpose of determining reasonable accommodations.

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

### **Diagnosing Professional Section:**

To ensure reasonable and appropriate accommodations, employees must provide current documentation of the disability. The Americans with Disabilities Act as Amended defines a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment. As the diagnosing professional, you are asked to fully complete all sections of this form. Additional reports or information can be attached if necessary. We have attached a job description for your review, including essential job functions and an ADA checklist. Thank you for your assistance.

**Employee Name:** \_\_\_\_\_ **Date of Exam:** \_\_\_\_\_

**I. Diagnosis** (*Please attach test results, e.g. an eye report with visual acuity and fields, audiology report, PT/OT evaluation, neuropsychological report, etc., and any additional information as necessary.*)

Primary Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

History of Illness: \_\_\_\_\_

Describe the nature and severity of the impairment: \_\_\_\_\_

Is the condition persistent and long-term? \_\_\_\_\_

If temporary, what is the expected duration? \_\_\_\_\_

*-Continued on next page-*

**II. Medication and/or Corrective Measures**

Describe whether medication and/or corrective measures that may correct the impairment have been prescribed (e.g. medication lowers high blood pressure to acceptable level, or corrective lenses improve vision to 20/40).

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**III. Substantial Functional Limitations**

*Definition: Employee is significantly restricted in comparison to the average person in the general population as to the conditions, manner or duration under which activities can be performed.*

How does the impairment, in its corrected or medicated condition, affect the employee in the activities required in the workplace? Does the condition interfere with the employee’s major life activities, and to what extent? (Major life activities include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working. This list is not exhaustive. Major life activities also includes major bodily functions which includes, but is not limited to:

- functions of the immune system
- cell growth,
- digestive, bladder and bowel functions
- neurological and brain functions
- respiratory and circulatory functions
- endocrine functions
- reproductive functions

List the **substantial functional limitations** (e.g. cannot read regular size print, slow reading speed, slow speech, limited dexterity, or other).

Diagnosis/Condition(s): \_\_\_\_\_  
\_\_\_\_\_

Major Life Activity(ies): \_\_\_\_\_  
\_\_\_\_\_

Substantial Functional Limitation(s): \_\_\_\_\_  
\_\_\_\_\_

**IV. Recommended Accommodations**

Please list your recommended accommodations (e.g. accessible buildings, alternate format materials such as large print, Braille, assistive technology, or other).

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If the requested accommodation is time off from work, how much leave is recommended? \_\_\_\_\_

Are there any activities or situations that should be avoided or that would present a significant risk of serious injury or death for the employee or others? \_\_\_\_\_

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**Thank you for your assistance in providing this information so that we may provide services as soon as possible. Please attach your business card or other form of identification and send this document to:**

**Director of Employee Relations / ADA Coordinator  
The University of North Carolina at Asheville  
Phillips Hall, CPO #1450  
One University Heights  
Asheville, NC 28804-8503**

**Certifying Qualified Medical Provider/License Number:** \_\_\_\_\_

**Name/Degrees/Title:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_