Office of Equal Opportunity

Documentation of Disability

This form is to be completed by an NC State Employee[1] and their Healthcare Provider for the purposes of determining eligibility to receive workplace accommodations on the basis of disability as articulated under the Americans with Disabilities Act of 1990, as amended.

Release of Information

Employee Information	
Name:	Email:
Job Title:	Employee ID:

By signing below, I hereby authorize the release of the following information to the ADA Coordinator for the purpose of determining my eligibility as a person with a disability on the campus of NC State University.

Signature: **Date:**

Dear Healthcare Provider,

The above-identified individual is affiliated with NC State University and is requesting to receive accommodations on the basis of disability. Under the Americans with Disabilities Act of 1990, a disability is defined as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment."

Through an interactive process, NC State must determine if an employee is eligible for accommodations and, if so, identify reasonable accommodations by determining if the employee has a physical or mental impairment that substantially limits a major life activity, like caring for oneself, performing manual tasks, w alking, seeing, hearing, speaking, breathing, learning, etc. Eligibility is based on documented clinical data not simply on self-report or evidence of a diagnosis. **Therefore, as part of this process, the above-identified individual and NC State are requesting current documentation from you. Please supply the following details to NC State:**

1. **Complete all five sections of this form in full**
2. **Provide a written narrative on letterhead that includes the following information:**
   a. a specific and current diagnosis(es);
   b. a description of the limitations the employee experiences in the workplace as a result of this diagnosis; and
   c. whether or not accommodations will be needed when utilizing medications and/or corrective measures
3. **Submit these materials to NC State's ADA Coordinator:**

   Sheri Schwab, ADA Coordinator
   NC State University Campus Box 7530, Raleigh, NC 27695-7530
   Fax: 919.513.1428 or Email: equalopportunity@ncsu.edu

NC State's ADA Coordinator will review the documentation you provide to determine eligibility and explore reasonable accommodations as appropriate. The ADA Coordinator, or designee, may follow up with you should additional information be required as part of this process. **Failure to do the steps above may interfere with the employee receiving a timely eligibility decision.** Thank you for your time and assistance in this process.

[1] *Note:* This form is applicable to employees, guests, visitors, and other affiliates of NC State.

STEP 1: Information regarding the employee's physical or mental impairment

Attach any test results or reports that substantiate the following information.

Primary Diagnosis:	**CODE:**
Date of diagnosis:	

• Is the impairment:
  • chronic;
  • long-term; or
  • temporary.
• If the impairment is temporary, what is the expected duration?	

History of impairment:	

Date of last visit:
How often do you provide treatment?

Secondary Diagnosis:	**CODE:**
Date of diagnosis:	

• Is the impairment:
  • chronic;
  • long-term; or
  • temporary.
• If the impairment is temporary, what is the expected duration?	

History of impairment:	

STEP 2: Information regarding the employee's affected major life activity

Which, if any, of the major life activities does the physical or mental impairment(s) affect?

- ☐ Bending
- ☐ Breathing
- ☐ Caring for Oneself
- ☐ Communicating
- ☐ Concentrating
- ☐ Eating
- ☐ Hearing
- ☐ Other:
- ☐ Interacting with Others
- ☐ Learning
- ☐ Lifting
- ☐ Performing Manual Tasks
- ☐ Reaching
- ☐ Reading
- ☐ Seeing
- ☐ None
- ☐ Sitting
- ☐ Sleeping
- ☐ Speaking
- ☐ Standing
- ☐ Thinking
- ☐ Walking
- ☐ Working*

*** If you checked "working" as the affected major life activity, please provide more detailed information by checking all components of "working" that are substantially limited:**

- ☐ Acquiring new workplace knowledge/skills
- ☐ Being present at work location
- ☐ Communication (verbal and/or written)
- ☐ Complying with safety and health requirements
- ☐ Demonstrating workplace knowledge/skills
- ☐ Developing/maintaining working relationships
- ☐ Fulfilling essential job responsibilities
- ☐ Judgment and appropriate behavior
- ☐ Leading others
- ☐ Organizing effectively and efficiently
- ☐ Performing at an acceptable level
- ☐ Regular attendance

Should you need to clarify or specify additional details, please indicate that information in the space below.

STEP 3: Information regarding the employee's substantial limitations

Information is needed about how the 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 physical or mental impairment, in its corrected or medicated condition, affect the employee in the activities required in the workplace?

Please list below any **substantial functional limitations**, how often they occur, how long they last, and the severity of each.

Substantial Functional Limitations	**Frequency/Duration** (daily, weekly, hours, days, etc.)	**Severity** (mild, moderate, severe)
1.		
2.		
3.		
4.		
5.		

Are there any activities or situations that the employee is unable to perform or would pose a direct threat to health or safety (significant risk of substantial harm to the health or safety of the individual or others)?

Which accommodations, if any, do you recommend? (This is for informational purposes only. NC State University will determine what, if any, reasonable accommodations may apply.)

STEP 4: Written Narrative

Please provide a written narrative, signed, dated, on letterhead with this form and provide the following details:

1. a specific, current diagnosis (within one year);
2. a description of the limitations the employee currently experiences in the workplace; and
3. whether or not accommodations will be needed when utilizing medications and/or corrective measures.

STEP 5: Healthcare Provider's Contact Information and Signature

Please attach your business card here:

Front

Back

Please provide the following information:

Name & Title:	Business Name:
License Certification:	Business Address:
State:	
Area(s) of Specialization:	Email:
	Phone:
	Fax:

Healthcare Provider's Signature
I, the undersigned, attest that the information provided in this documentation is accurate as of the date of its submission.

Signature of Healthcare Provider *Date*