



ADA Disability Verification Form (to be completed by medical provider)

TO THE EMPLOYEE: Please complete the ADA Request for Reasonable Accommodation Form and forward to the Department for Disability Support Services, Att: ADA Coordinator. Sign the Release of Information statement below and have your physician or medical provider complete and send this form directly to ECU'S Department for Disability Support Services, ADA Coordinator, Slay 138, East Carolina University, Greenville, NC 27858.

Questions may be directed to the ADA Coordinator at (252) 737-1016 voice or TTY

Release of Information Statement (to be completed by the employee)

I _____ (please print), hereby authorize my health care provider to furnish the following information to East Carolina University, The Department for Disability Support Services, ADA Coordinator, Slay 138, Greenville, NC 27858.

Employee Signature

Date

To the Health Care Provider: (Please complete the following or attach documentation addressing A, B, C, D & E)

The employee indicated below recently requested an accommodation in the workplace under the provisions of the Americans with Disabilities Act (ADA). To ensure reasonable and appropriate accommodations, employees must provide current documentation of the disability. The Americans with Disabilities Act defines a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such 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 as necessary. Thank you for your assistance.

A. Diagnosis (please attach relevant test results)

Primary Diagnosis:

Date of Diagnosis:

Date of last visit:

Describe the nature and severity of the impairment:

Is the condition persistent and long term:

If temporary, what is the expected duration?

B. Medication and/or Corrective Measures

Describe whether medication and/or corrective measures that may correct the impairment have been prescribed:

C. Substantial Functional Limitation

Which of the following major life activities are substantially limited by the impairment (circle all that apply):

walking seeing speaking hearing breathing learning performing manual tasks caring for oneself

sitting standing lifting learning other _____

How does the condition affect the employee's ability to perform essential functions of their job?

D. Recommended Accommodations

What accommodations do you recommend?

If the requested accommodation is time taken off from work, how much 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?

E. Qualifications of Certifying Provider (please print)

Name: _____ Degree: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

Signature _____ Date _____

Please return this form to :

ADA Coordinator
Department for Disability Support Services
East Carolina University
138 Slay
Greenville, NC 27858
(252) 737-1016 (v/tty)
(252) 737-1025 fax

