NC STATE UNIVERSITY

Documentation of Disability
Form ADA-002

EMPLOYEE: Release of Information

I, ____, hereby authorize the release of
Employee Name – Please Print
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: ___________________

TO THE HEALTHCARE PROVIDER:

Employees requesting a disability eligibility review for the purpose of receiving accommodations at NC State University are required to provide current documentation about their physical or mental impairment. Documentation standards to determine legal eligibility are more stringent than for usual clinical practice. Eligibility is based on documented clinical data not simply on self-report or evidence of a diagnosis. The university's ADA Coordinator will review the documentation you provide. The purpose of the review is to determine whether or not the employee has a "disability," as defined by the Americans with Disabilities Act (ADA) of 1990. The definition of "disability" as outlined in this Act, is tailored for the purpose of eliminating discrimination, and therefore, may differ from the definition of "disability" under other statutes.

As the healthcare provider, please complete fully all sections of this form and provide a brief narrative. Failure to do either may interfere with the employee receiving a timely eligibility decision.

Documentation should be sent directly to:
Sheri Schwab
ADA Coordinator
NC State University
Campus Box 7530
Raleigh, NC 27695-7530
FAX: 919-513-1428
Questions may be directed to our office at 919-513-0574 or equalopportunity@ncsu.edu

PLEASE NOTE: ALL INFORMATION PROVIDED MIGHT BE SHARED WITH THIS EMPLOYEE UNLESS CLEARLY MARKED OTHERWISE.

For purposes of the ADA, a healthcare provider must provide clear and precise documentation that allows the ADA Coordinator to answer the following question as part of a 3-step inquiry:

Does the employee have a physical or mental impairment that substantially limits a major life activity, like caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working?

THE 3-STEP INQUIRY

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: ____________________

History of impairment: ____

____

Nature and severity: ____

Is the impairment chronic or long-term? ____

If the impairment is temporary, what is the expected duration? ____________________

Secondary diagnosis: ____ **CODE:** __________

Date of diagnosis: ____________________

History of impairment: ____

____

Nature and severity: ____

Is the impairment chronic or long-term? ____

If the impairment is temporary, what is the expected duration? ____________________

Other diagnosis: ____ **CODE:** __________

Date of diagnosis: ____________________

History of impairment: ____

____

Nature and severity: ____

Is the impairment chronic or long-term? ____

If the impairment is temporary, what is the expected duration? ____________________

Date of last visit: ____________________

How often do you provide treatment? ____

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?

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

*** 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:**

_____ Fulfilling essential job responsibilities

_____ Performing at an acceptable level

_____ Demonstrating workplace knowledge/skills

_____ Acquiring new workplace knowledge/skills

_____ Judgment and use of appropriate occupational behaviors

_____ Communicating: verbal ________ written ________

_____ Developing/maintaining working relationships

_____ Regular attendance

_____ Organizing effectively and efficiently

_____ Leading others

_____ Complying with safety and health requirements

_____ Being present at work location

Notes: ____

____

____

____

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? List the following: the specific ***substantial functional limitations***, how often they occur, how long they last, and the severity of each.

Limitations	**Frequency/Duration** (daily, weekly, etc./# hours, days, etc.)	**Severity** (mild, moderate, severe)

Are there any activities or situations that should be avoided by this employee 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. If required, NC State University will determine the appropriate, reasonable accommodations.)

____

____

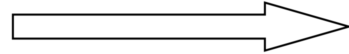
____

WRITTEN NARRATIVE

A written narrative, signed, dated, and on letterhead, must be submitted with this form. The narrative can be brief, but must include:

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

PLEASE ATTACH YOUR BUSINESS CARD HERE:



Name/Title: ____________________

Business Name: ____________________

Business Address: ____________________

Phone: ____________________

Fax: ____________________

Email: ____________________

Professional Credentials: ____________________

License Certification: ____________________

State: ____________________

Area of Specialization: ____________________

Signature: ____________________ **Date:** ____________________