ELIZABETH CITY STATE UNIVERSITY
Documentation of Disability Form

TO BE COMPLETED BY A PHYSICIAN OR QUALIFIED HEALTH CARE PROFESSIONAL

Elizabeth City State University (ECSU) requires employees/applicants requesting an accommodation under the Americans with Disabilities Act (ADA) to provide current documentation about their physical or mental impairment(s). Eligibility is based on documented clinical information/data, not just self report or evidence of diagnosis. The purpose of this form is to assist ECSU in determining whether or not the employee/applicant listed below has a disability as defined by the ADA; and if yes, whether or not a reasonable accommodation can be granted to assist the employee/applicant in performing one or more essential functions of the job safely and effectively. As the diagnosing professional, we ask that you complete fully all sections and provide a brief narrative where applicable. Please review the attached job description or classification specification for the employee/applicant prior to completing this form.

Employee Information:

Name: _______________________________________ Gender: ☐ Male ☐ Female
Employee: ☐ Applicant: ☐
Department/Unit: _____________________________ Position/Title: _______________________
Current Work Schedule/Shift: _______________________________________________________

Primary Diagnosis: (Must be current.)

Date of Diagnosis: ___________________________
Diagnosis (including a brief narrative statement of the findings from any test results):
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
History of Diagnosis: ___________________________________________________________
_________________________________________________________________________
Nature and Severity of Diagnosis: _______________________________________________
_________________________________________________________________________
Length of Diagnosis (i.e. temporary or long-term): ________________________________
_________________________________________________________________________
If Temporary, expected duration: ________________________________________________
Other Related Diagnosis: (Must be current.)

Date of Diagnosis: ___________________________

Diagnosis (including a brief narrative statement of the findings from any test results):
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

History of Diagnosis: _______________________________________________________________

Nature and Severity: ________________________________________________________________
_________________________________________________________________________________

Length of Diagnosis (i.e. temporary or long-term): ________________________________________
_________________________________________________________________________________

If Temporary, expected duration: ______________________________________________________
_________________________________________________________________________________

Employee’s/Applicant’s Affected Major Life Activities:
Please check any and all major life activities affected by the diagnosis:

☐ Seeing
☐ Hearing
☐ Speaking, Communicating
☐ Eating
☐ Sleeping
☐ Working
☐ Walking, Standing, Lifting, Bending
☐ Breathing
☐ Performing Manual Tasks
☐ Learning, Reading, Concentrating, Thinking
☐ Caring for Self
☐ None

Employee’s/Applicant’s Affected Major Bodily Functions:
Please check any major bodily functions affected by the diagnosis:

☐ Immune System
☐ Endocrine
☐ Respiratory
☐ Reproductive
☐ None
☐ Digestive, Bowel, Bladder
☐ Neurological, Brain
☐ Circulatory
☐ Normal Cell Growth
Substantial and/or Significant Restrictions or Limitations:

Please describe below how the employee’s/applicant’s physical or mental impairment substantially or significantly restricts his/her ability to perform job duties as set forth in the enclosed job description:

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<th>Restrictions or Limitations</th>
<th>Frequency/Duration</th>
<th>Severity (Mild/Moderate/Severe)</th>
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Accommodations

Please describe any accommodations the above-referenced employee/applicant may require to perform job functions safely and effectively in your opinion:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Physician/Health Care Provider Information:

Name and Title: __________________________
Name of Hospital/Practice: __________________________
Address: __________________________
Telephone: __________________________
Signature: __________________________
Date: __________________________

THIS FORM SHOULD BE RETURNED DIRECTLY TO:

Equal Opportunity/ADA Office
Elizabeth City State University
1704 Weeksville Road, CB#944
Elizabeth City, NC 27909