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:

Restrictions or Limitations	Frequency/Duration	Severity (Mild/Moderate/Severe)

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