ADA & ADAA Disability Verification Form

East Carolina University is committed to compliance with the Americans with Disabilities Act (1990) and the Americans with Disabilities Amendments Act (2008). The purpose of this form is to assist East Carolina University in determining whether, or to what extent, a reasonable accommodation will allow an employee to perform his or her job safely and effectively.

To be completed by employee:

Name: ___________________________  Brief Job Description: ___________________________

By my signature below I hereby authorize my health care provider _____________________________ to furnish the following information to the Office of the ADA Coordinator at East Carolina University. I further agree that the ADA Coordinator may contact my health care provider named above to obtain additional information related to my limitations and recommended accommodations. I understand that relevant information obtained may be shared with my supervisor(s) and other University offices that may be involved in assisting with the establishment of reasonable accommodations. We will not share your diagnosis with your supervisor; however, we need to share specific functional limitations that are the basis for reasonable accommodations, in order to evaluate your request for accommodation. Disability-related medical information may also be released, to the extent applicable, to government officials who are auditing the employer’s compliance with the ADA.

__________________________  ____________
Signature Date

To be completed by the health care provider:

Note: In compliance with the Genetic Information Nondiscrimination Act of 2008 (GINA), please do not provide genetic or family history information in response to this request.

Please list diagnosis that are related to the employee’s ability to perform essential functions of his/her job.

Diagnosis ___________________________________________ Date of Diagnosis ____________

Is the condition listed above (please circle) permanent temporary episodic
If temporary, estimated length of recovery period _________________
If episodic, estimated length of time between flare-ups _______________
Result of condition: ___mild impairment ___moderate impairment ___severe impairment

Diagnosis ___________________________________________ Date of Diagnosis ____________

Is the condition listed above (please circle) permanent temporary episodic
If temporary, estimated length of recovery period _________________
If episodic, estimated length of time between flare-ups _______________
Result of condition: ___mild impairment ___moderate impairment ___severe impairment
According to the Americans with Disabilities Amendments Act, *major life activities* may include but are not limited to the following, please check all that are impacted by the physical or mental impairment of the employee:

- [ ] caring for oneself
- [ ] performing manual tasks
- [ ] seeing
- [ ] hearing
- [ ] eating
- [ ] sleeping
- [ ] walking
- [ ] standing
- [ ] lifting
- [ ] bending
- [ ] speaking
- [ ] breathing
- [ ] learning
- [ ] reading
- [ ] concentrating
- [ ] thinking
- [ ] communicating
- [ ] working

Also included are functions of

- [ ] the immune system
- [ ] digestion
- [ ] the bowels
- [ ] the bladder
- [ ] reproduction
- [ ] the endocrine system
- [ ] normal cell growth
- [ ] circulation
- [ ] neurological processes
- [ ] the brain
- [ ] respiration

Other: ________________________________________________________________

Given the limitations described above and your knowledge of the job related activities of the employee, what accommodations do you recommend that will enable the individual to perform the essential functions of his/her job?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Provider Information

Name: ___________________________________ Area of specialty: ___________________________________
Practice Address: ________________________________
Phone: ____________________ Email: ____________________
Signature ___________________ Date ____________________