



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 their 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 the ADA Coordinator will only share the minimum amount of information necessary 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 may need to share specific functional limitations that are the basis for reasonable accommodations in order to evaluate and/or implement 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 their 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:

- | | |
|--|--|
| <input type="checkbox"/> caring for oneself | <input type="checkbox"/> bending |
| <input type="checkbox"/> performing manual tasks | <input type="checkbox"/> speaking |
| <input type="checkbox"/> seeing | <input type="checkbox"/> breathing |
| <input type="checkbox"/> hearing | <input type="checkbox"/> learning |
| <input type="checkbox"/> eating | <input type="checkbox"/> reading |
| <input type="checkbox"/> sleeping | <input type="checkbox"/> concentrating |
| <input type="checkbox"/> walking | <input type="checkbox"/> thinking |
| <input type="checkbox"/> standing | <input type="checkbox"/> communicating |
| <input type="checkbox"/> lifting | <input type="checkbox"/> working |

Also included are functions of

- | | |
|---|---|
| <input type="checkbox"/> the immune system | <input type="checkbox"/> normal cell growth |
| <input type="checkbox"/> digestion | <input type="checkbox"/> circulation |
| <input type="checkbox"/> the bowels | <input type="checkbox"/> neurological processes |
| <input type="checkbox"/> the bladder | <input type="checkbox"/> the brain |
| <input type="checkbox"/> reproduction | <input type="checkbox"/> respiration |
| <input type="checkbox"/> the endocrine system | |

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 their job?

Provider Information

Name: _____ Area of specialty: _____

Practice Address: _____

Phone: _____ Email: _____

Signature

Date