



DOCUMENTATION OF DISABILITY

This form is for University ADA Services to determine whether an employee qualifies under the Americans with Disabilities Act (ADA), the ADA Amendments Act of 2008 (ADAAA).

Section 1: To be completed by employee:

Employee Name

Job Title

Department

Supervisor

Release of Information:

I hereby authorize the release of the information provided by my physician or care provider in section 2 below to Western Kentucky University for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Western Kentucky University to seek clarification of this documentation, if necessary, by contacting my physician or care provider and I authorize my physician or care provider to respond to such requests for clarification.

(Employee Signature)

Treating Professional Contact Information:

(Name)

(Street Address)

(City/State/Zip Code)

(Phone No.)

Section 2: To be completed by the physician or care provider:

Please answer and return the following form to The Office of Equal Opportunity/Affirmative Action/University ADA Services within the time frame indicated. The questionnaire format is a guide and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions if needed to answer more fully. Thank you for your anticipated cooperation.

IMPORTANT NOTE TO HEALTH CARE PROVIDER: When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics, including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

1. Does the individual have a current disability? Yes No
(According to the ADA, a "person with a disability" is defined as anyone with a physical or mental impairment that substantially limits one or more major life activities.)

a. If yes, what specifically is the diagnosis/condition? _____

b. What is the nature of the condition? _____

2. Is this a medical, psychological or physical condition that affects a major life activity?
 Yes No *(Check all of the following that apply).*

Walking		Speaking		Breathing
Hearing		Seeing		Concentration
Working		Standing		Reaching
Sleeping		Learning		Lifting
Memory		Thinking		Sitting
Performing Manual Tasks		Caring for Oneself		Interacting with Others
Major Bodily Functions		Other		

3. Additional life activities affected: _____

4. Does this employee's condition **substantially** limit the major life activity listed above?
 Yes No

a. How is the individual substantially limited in the major life activity identified above? _____

b. Discuss evidence of the disability: _____

c. What is the severity? _____

d. Please list any prescribed medications that controls all or some of the symptoms?

e. Are there impacts or side effects from the medications?
Yes No
If so, what are they? _____

f. What are the expected duration and the long-term impact of this condition?

g. Is this a chronic or episodic disability that is substantially limiting when active?
Yes No
If yes, please explain. _____

5. List appropriate accommodations that you recommend for this individual.

Additional notes or comments: _____

Treating Professionals Name: _____
(Please Print)

Signature: _____ Date: ____/____/____

Name of Practice: _____

Phone (____) _____ - _____ Fax (____) _____ - _____

PLEASE MAIL OR FAX THIS COMPLETED FORM TO THE FOLLOWING DEPARTMENT:

The Office of Equal Opportunity/Affirmative Action/University ADA Services
1906 College Heights Blvd. #11009
Bowling Green, KY 42101
Ph: 270-745-5121/TDD 711 Fax: 270-745-3199
Email: adacompliance@wku.edu