Documentation of Disability
Employee Information and Care Provider Statement

Section 1.To be completed by employee

Employee Name_____ Job Title_____

Department/College_____ Supervisor_____

Release of Information

I hereby authorize the release of the following information to Villanova University for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Villanova University to seek clarification of this documentation if necessary by contacting my care provider.

_____

Employee Signature **Banner ID** **Date**

The Disability Accommodation Request Form and Documentation of Disability are necessary to begin the accommodation process. Departments may make job modifications to assist an employee, even if the condition is not a disability. Making such modifications does not indicate the employee is considered disabled. Departments may consult with Human Resources for assistance.

Section 2.To be completed by health care provider

To Health Care Provider:

To request reasonable and appropriate accommodations, employees must provide current documentation of a disability. Federal and state law define a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment. As the employee's health care provider, you are asked to fully complete all sections of this form. Additional information can be attached if necessary.

To complete this form (see attached, page 2 section 2), you must review the employee's job description and other information relevant to the employee's job at Villanova University. If those materials have not been provided, please contact the employee and let him or her know you cannot complete this form without those materials. Thank you for your assistance

To comply with the Genetic Information Nondiscrimination Act of 2008 (GINA), please do not provide any genetic information when responding to this request for medical information. *"Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member.*

Page 2, Section 2 **Employee Name** _____

1. Please identify the employee's physical or mental impairment.

   Please describe the duration of this impairment (e.g., long-term, permanent, recent, short-term).

2. Please describe the effects or limitations this impairment has on the employee's activities, if any.

   Please describe whether medication and/or corrective measures have been prescribed or recommended that may reduce or eliminate any of these limitations.

3. By reviewing the attached information concerning the employee's job duties, please describe the effect or limitations this impairment has on the employee's ability to perform the job duties, if any.

   Are there any activities or situations that should be avoided or that would present a health or safety risk to the employee or others due to the impairment?

4. Please offer any suggested accommodations that might enable the employee to perform his or her job duties.

Suggestions	**Duration?**

Thank you for your assistance in providing this information so that we may assess the employee's request. Please sign below.

Providers Name (Please Print): _____

Provider's Signature: _____ **Date:** _____