Villanova University
Documentation of Disability
Employee Information and Health Care Provider Statement

Section 1.To be completed by employee

Employee Name______________________________ Job Title_________________________

Department/College____________________________ Supervisor________________________

Release of Information
I hereby authorize the above named health care provider to complete this form and disclose to Villanova University and its authorized representatives the following information relating to my health care: the diagnosis(es) of relevant conditions, treatment plan(s), my ability to perform my work, recommendations, history, reports and correspondence.

I understand that it may be necessary for the University representative to share this information for the purpose related to accommodation of a disability. I authorize the University to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.

Once disclosed, the law does not always require the recipient of my information to maintain the confidentiality of my health care information. I understand that information obtained under this release is a confidential medical record and is maintained separate from my personnel file.

I hereby authorize my health care provider to discuss directly with University representatives any medical/health information relevant to establish the nature, severity and duration of the impairment for which I am making my accommodation request.

By signing this page, I acknowledge that I have read and agree to the terms described above. (NOTE TO EMPLOYEE: If you do not provide authorization for your health care provider to discuss the medical/mental/health information relevant to your accommodation request, processing of your accommodation request may be delayed.)

____

Employee Signature **Date** **Banner ID (if known)**

(To Employee: DO NOT RETURN THIS FORM TO YOUR DEPARTMENT SUPERVISOR); Return all completed employee and health care provider portions of this form to

Human Resources Department, Attn: Disability Benefits Analyst
Villanova University
800 E. Lancaster Avenue, Villanova, PA 19085
(610) 519-4239 (direct line); (610) 519-6667 (fax)

If this form is faxed, please send original by mail.

The “Employee Disability Accommodation Request Form” and this form 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.

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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.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with the law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, 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 or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee Name ____________________________

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

   Please describe this impairment (e.g., long-term, short-term, permanent)

   If not permanent, how long will the impairment likely last?

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2. Does the impairment substantially limit a major life activity?

   If yes, what major life activity(ies) is/are affected?

Caring for self		Thinking		Sitting	
Walking		Concentrating		Lifting	
Hearing		Working		Standing	
Seeing		Interfacing with Others		Toileting	
Speaking		Performing Manual Task		Sleeping	
Breathing		Reaching		Reproduction	
Learning		Other (Describe below)			

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

3. Does the impairment substantially limit the operation of a major bodily function?

   If yes, what major bodily function(s)?

Immune		Hemic		Circulatory	
Endocrine		Digestive		Lymphatic	
Bowel		Brain		Bladder	
Reproductive		Neurological		Respiratory	
Cardiovascular		Genitourinary		Musculoskeletal	
Special Sense		Special Sense Organ & Skin		Normal Cell Growth	
Other (Describe)					

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

4. By reviewing the attached information concerning the employee's job duties, please describe if any limitation(s) is/are interfering with the employee's ability to perform his/her job.

5. What job function(s) is the employee having trouble performing because of the limitation(s)?

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6. How does the employee's limitation(s) interfere with his/her ability to perform those job functions?

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

7. Please offer any suggested accommodations that might enable the employee to perform his or her job duties and provide a description of how his/her job performance will improve.
8.

Suggestions	Duration?

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

Provider's Name (Please Print): ____

Provider's Signature: ________________________________ **Date:** __________________