Department for Disability Support Services
Office of the ADA Coordinator
East Carolina University
Slay 138 • Greenville, NC 27858-4353
252-737-1016 voice/TDD • **252-737-1025** fax

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 the essential functions of 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.

_____ _____
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: _____ Fax: _____

_____ _____
Signature Date