Documentation of Disability Form
COVID-19 Accommodation Requests

Section 1: Instructions

This form should be completed and signed by a physician or qualified healthcare professional. The Equal Opportunity and Compliance Office (EOC) requires that employees requesting an accommodation provide current documentation about their physical or mental impairment. Eligibility is based on documented clinical data, not just self-report or evidence of diagnosis.

The purpose of this form is to assist the University of North Carolina at Chapel Hill in determining whether or not an employee has a disability as defined by the Americans with Disabilities Act (ADA); and if yes, whether or not a reasonable accommodation can be granted to assist the employee in performing one or more essential functions of their job safely and effectively.

It is the requesting employee's responsibility to ensure that adequate medical information is provided. Incomplete or inadequate forms will be returned to the employee to obtain additional information from the provider. Employees must provide complete, adequate medical information within two weeks of submitting their Accommodation Request form. If the employee does not submit complete, adequate medical information within that timeframe, the EOC will understand that the employee is not participating in the interactive process and will close the accommodation request. The employee may reinitiate the interactive process at any time by submitting complete medical information. Employees should note that EOC is not able to grant retroactive accommodations.

Section 2: Employee Information

Name: _____

Department/Unit: _____

Position/Title: _____

Current Work Schedule/Shift:_____

Section 3: Employee Health Information

Has this employee been vaccinated against COVID-19? ☐ Yes ☐ No

If yes, what was the date of the employee's final vaccine? _____

If no, is this employee medically unable to receive the COVID-19 vaccine? _____
If yes, see below.

If this employee is not yet vaccinated, does this employee plan to get vaccinated? ☐ Yes ☐ No

If yes, what will be the date of the employee's final vaccine? _____

If the employee is medically unable to receive the COVID-19 vaccine, please complete the following:

1. What is the medical condition that causes the employee to be medically unable to receive the vaccine?

   _____

2. Why does that medical condition cause the employee to be medically unable to receive the vaccine?

   _____

   _____

   _____

   _____

   _____

3. Does the employee have a medical condition that places them at higher risk of contracting COVID-19 or experiencing more severe COVID-19 complications if contracted? What is the medical condition?

   _____

   _____

   _____

   _____

   _____

If the employee has or is able to receive(d) the COVID-19 vaccine, does the employee have a medical condition that reduces the efficacy of the COVID-19 vaccine? What is the medical condition? What is the basis for your determination that the efficacy will be reduced?

_____

_____

_____

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_____

Please thoroughly describe any other medical need for accommodations related to COVID-19.

_____

_____

_____

_____

_____

Accommodations:

Please check all accommodations that would enable the employee to perform their job functions safely and effectively:

1. Telework ☐
2. Private on-campus workspace ☐
3. Maintaining _____ feet of distance and wearing a mask ☐

If options 2 or 3 are not selected, please explain why those options would not enable the employee to perform their job functions safely and effectively.

_____

_____

_____

_____

Please indicate the anticipated duration of the need for an accommodation. If the anticipated duration is dependent upon reaching a community vaccination level (i.e., 60% or herd immunity), please explain whether you anticipate the employee being able to return to work on site if that level is not reached.

_____

_____

_____

Physician/Health Care Provider Information:

Name and Title:_____

Name of Hospital/Practice:_____

Address:_____

Telephone:_____

Signature & Date:_____

THIS FORM SHOULD BE RETURNED DIRECTLY TO:

EQUAL OPPORTUNITY AND COMPLIANCE OFFICE
University of North Carolina at Chapel Hill
214 W. Cameron Ave., CB# 9160
Chapel Hill, NC 27599-9160
FAX: 919-445-1580