UNC
EQUAL OPPORTUNITY
AND COMPLIANCE OFFICE

EQUAL OPPORTUNITY AND COMPLIANCE OFFICE
214 W. CAMERON AVE. CAMPUS BOX 9160
CHAPEL HILL, NC 27599-9160
PHONE: 919.966.3576 / **FAX:** 919.445.1580

ADA Documentation of Disability Form

--TO BE COMPLETED BY A PHYSICIAN OR QUALIFIED HEALTH CARE PROFESSIONAL--

IMPORTANT: Please Enclose Job Description/Classification Specifications for Your Provider!

The Equal Opportunity and Compliance Office 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 his or her job safely and effectively. As the diagnosing professional, we ask that you complete fully all sections and provide a brief narrative where applicable. Please review the job description or classification specification prior to completing this form.

Employee Information:

Name: ______________________________

Department/Unit: ______________________ Position/Title: ______________________________

Current Work Schedule/Shift: ____

Primary Diagnosis: (Must be ***current***; please attach any related test results.)

Date of Diagnosis: ____________________

Diagnosis: ____

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History of Diagnosis: ____

Nature & Severity: ____

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Temporary or Long-term: ____

If Temporary, Duration: ____

The University of North Carolina at Chapel Hill is an Equal Opportunity Employer

Other Diagnosis: (Must be ***current***; please attach any related test results.)

Date of Diagnosis: ______________________

Diagnosis: ____

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History of Diagnosis: ____

Nature & Severity: ____

____

Temporary or Long-term: ____

If Temporary, Duration: ____

Employee's Affected Major Life Activities:

- ☐ Seeing
- ☐ Hearing
- ☐ Speaking, Communicating
- ☐ Eating
- ☐ Sleeping
- ☐ Working**
- ☐ Walking, Standing, Lifting, Bending
- ☐ Breathing
- ☐ Performing Manual Tasks
- ☐ Learning, Reading, Concentrating, Thinking
- ☐ Caring for Self
- ☐ None

Employee's Affected Major Bodily Functions:

- ☐ Immune System
- ☐ Endocrine
- ☐ Respiratory
- ☐ None
- ☐ Digestive, Bowel, Bladder
- ☐ Neurological, Brain
- ☐ Circulatory

Substantial and/or Significant Restrictions or Limitations:

** Please describe how the employee's physical or mental impairment substantially or significantly restricts their ability to perform workplace activities:

Restrictions or Limitations	Frequency/Duration	Severity (Mild/Moderate/Severe)

Accommodations:

Please describe any accommodations that the employee may require to perform job functions safely and effectively:

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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