



# Documentation of Disability Form

Form EEO-010

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## To the Employee:

To initiate this request, please complete Form EEO-009, the Accommodation Request Form, and have your physician or medical provider complete this form. Sign the Release of Information below and have your physician or medical provider send this form directly to Dr. Cheryl Branker, Associate Vice Provost and Director of Disability Compliance Programs, 1900 Student Health Center, NCSU, Raleigh, NC 27695-7509. Questions may be directed to Dr. Branker at 919-513-3768.

## Release of Information:

I, \_\_\_\_\_, hereby authorize the release of the following information to NC State University for the purpose of determining reasonable accommodations.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## To the Diagnosing Professional:

To ensure reasonable and appropriate accommodations, employees must provide current documentation of the disability. The Americans with Disabilities Act defines 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 diagnosing professional, you are asked to fully complete all sections of this form. Additional reports or information can be attached if necessary. Thank you for your assistance.

**I. Diagnosis** *(Please attach test results, e.g., an eye report with visual acuity and fields, audiology report, PT/OT evaluation, neuropsychological report, etc., and any additional sheets as necessary.)*

Primary Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

History of Illness: \_\_\_\_\_

Describe the nature and severity of the impairment: \_\_\_\_\_

\_\_\_\_\_

Is the condition persistent and long-term? \_\_\_\_\_

If temporary, what is the expected duration? \_\_\_\_\_

## II. Medication and/or Corrective Measures

Describe whether medication and/or corrective measures that may correct the impairment have been prescribed (e.g., medication lowers high blood pressure to acceptable level; or corrective lenses improve vision to 20/40). *Continued on next page.*

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### III. Substantial Functional Limitations

**Definition:** Employee is *significantly* restricted in comparison to the average person in the general population as to the conditions, manner, or duration under which activities can be performed.

How does the impairment, in its corrected or medicated condition, affect the employee in the activities required in the workplace? Does the condition interfere with the employee's **major life activities**, and to what extent? (E.g., breathing, caring for self, hearing, learning, performing manual tasks, seeing, speaking, walking, working, or other). List the **substantial functional limitations** (e.g., cannot read regular size print, slow reading speed, slow speech, limited dexterity, or other).

Diagnosis/Condition(s): \_\_\_\_\_

Major Life Activity(ies): \_\_\_\_\_

Substantial Functional Limitation(s): \_\_\_\_\_

### IV. Recommended Accommodations

Please list your recommended accommodations (e.g., accessible buildings, alternate format materials such as large print, Braille, assistive technology, or other.)

If the requested accommodation is time off from work, how much leave is recommended? \_\_\_\_\_

Are there any activities or situations that should be avoided or that would present a significant risk of serious injury or death for the employee or others? \_\_\_\_\_

**Thank you for your assistance in providing this information so that we may provide services as soon as possible. Please attach your business card or other form of identification and send this document to:**

**Dr. Cheryl Branker, Disability Compliance Office, 1900 Student Health Center, NCSU, Raleigh, NC 27695-7509**

**Certifying Qualified Medical Provider/License Number:** \_\_\_\_\_

**Name/Degrees/Title:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ (ver. 10/10/05)