

***Disability Documentation***

***Form***

Ohio University provides accommodations for employees with disabilities intended to facilitate equal access to employment opportunities. To determine eligibility and appropriate accommodations, documentation regarding a physical or mental condition and its impact on the person’s function is requested from a licensed healthcare professional qualified to diagnose and treat the condition(s).

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Anticipated duration of the condition: 6 months 1 year more than 1 year

**Major Life Activities limited:**

On the following page is a checklist of the most frequently effected major life activities that could be impacted by the stated diagnosis. The limitation of Major Life Activity should be compared to the general population and should not take into account mitigating measures (e.g. medications or treatments that reduce the impact of the condition).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Major Life Activity** | **No Limitation** | **Mild Limitation** | **Moderate Limitation** | **Substantial Limitation** |
| Caring for one’s self |  |  |  |  |
| Eating |  |  |  |  |
| Sleeping |  |  |  |  |
| Concentrating |  |  |  |  |
| Bodily Functions |  |  |  |  |
| Talking |  |  |  |  |
| Hearing |  |  |  |  |
| Breathing |  |  |  |  |
| Lifting |  |  |  |  |
| Learning |  |  |  |  |
| Thinking |  |  |  |  |
| Interacting with others |  |  |  |  |
| Listening |  |  |  |  |
| Speaking |  |  |  |  |
| Seeing |  |  |  |  |
| **Major Life Activity** | **No Limitation** | **Mild Limitation** | **Moderate Limitation** | **Substantial Limitation** |
| Reading |  |  |  |  |
| Standing |  |  |  |  |
| Reaching/Grasping |  |  |  |  |
| Sitting |  |  |  |  |
| Walking |  |  |  |  |
| Performing Manual tasks |  |  |  |  |

Please list any side effects of current medication or treatment and the impacts they may have on the person:

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Have you and the person discussed the impacts of their condition at work? Y N

Do you have recommendations for reasonable accommodations to assist the person in performing the essential functions of their job?

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How else might the person’s disability limit their major life activities?

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The information I have provided is accurate to the best of my knowledge and the condition for which I treat the employee is within the scope of my professional licensure or certification.

Signature: Date:

Print Name, Title, Credentials:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: