

The University of North Carolina at Greensboro Employee Disability Verification

NOTE TO THE HEALTH CARE PROVIDER

The employee indicated below recently declared a disability and requested a reasonable accommodation in the workplace under the provisions of the Americans with Disabilities Act (ADA). The form on page two is to be completed by the health care provider and should be submitted to the Department of Human Resource Services with the employee's Reasonable Accommodation Request form. The information sought is job-related and consistent with business necessity for the following reasons:

- < to determine if the individual meets the ADA definition of "individual with a disability";
- < to determine if the individual is a qualified person under the ADA, meaning he or she can perform the essential functions of the job currently held, (or held before the injury or illness), with or without reasonable accommodation, and without posing a direct threat to health or safety of self or others that cannot be reduced or eliminated by reasonable accommodation; and
- < to identify an effective reasonable accommodation that would enable the individual to perform essential job functions in the current (previous) job, or in a currently vacant job for which the person is qualified (with or without accommodation.)

The responsibility of making employment decisions or deciding whether or not it is possible to make a reasonable accommodation for a person with a disability lies with officials from The University of North Carolina at Greensboro, not the health care provider.

MEDICAL AUTHORIZATION

(To be completed by the employee)

I, _____ do hereby authorize my health care provider to furnish to The University of North Carolina at Greensboro (hereinafter "UNCG"), P. O. Box 26170, Greensboro, NC 27402, all medical records, reports, medical charts, laboratory records and reports, x-rays and x-ray readings and reports, and any and all records pertaining to my medical case, history, condition, treatment, diagnosis or expenses, including my psychological status to the extent any such information has a bearing on my ability to perform the responsibilities and expectations of the essential functions of my position as a _____ (title) at UNCG. Be advised that pursuant to the laws of North Carolina, the information released could include information that could be considered information about communicable diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immune deficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS").

I also authorize UNCG, any of its employees, representatives and agents, to release information to my health care provider, including records and statements, regarding related background information giving rise to the request for reasonable accommodation and/or medical leave related to this medical authorization.

A facsimile or photocopy of this form will have the same force and effect as the original signed copy.

Employee's signature

Date

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(Over , please)

Employee Disability Verification Form

(To be completed by the Health Care Provider)

1) Employee's Name:

2) Date:

3) Job Title:

4) Department:

5) Please describe the employee's current health condition/disability:

6) Date condition/disability commenced:

7) Probable duration of condition/disability:

8) Does the employee's medical condition result in a physical¹ or mental impairment² that substantially limits one or more "major life activities"³ as defined by the Americans with Disabilities Act (ADA)? Yes No

If "Yes", please describe the functional limitations indicating which "major life activity" is affected:

9) Attached is a job description or information about the essential functions of the employee's position. Please circle any items listed on the job description that the employee may not be able to perform based on the employee's medical history and physical exam. Please indicate your opinion by selection of the following options:

Should be able to perform the essential job functions without accommodation; *or*

May not be able to perform the essential functions circled on the attached job description and a reasonable accommodation is not feasible; *or*

May not be able to perform the essential functions circled on the attached job description; however, the following reasonable accommodation(s) should be considered to help the individual perform these essential functions (please list your recommendation for reasonable accommodation):

10) (*Optional*) If necessary for the protection of the health and safety of this employee or others, please indicate special instructions for first-aid providers or supervisors:

(Signature of Health Care Provider)

(Date)

(Print Name of Health Care Provider)

(Type of Practice)

(Address)

(Telephone Number)

1. A physical impairment is defined by the ADA as: any physiological disorder, or condition, cosmetic disfigurement~ or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs) cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine.

2. A mental impairment is defined by the ADA as: 'any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.'

3. Examples of major life activities include walking, seeing, speaking, hearing, breathing, learning, performing manual tasks, caring for oneself, working, sitting, standing, lifting and reading.

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May, 1999