

**Documentation of Disability Form**

**TO BE COMPLETED BY A PHYICIAN OR QUALIFIED HEALTH CARE PROFESSIONAL IMPORTANT: Employee must provide his/her job description to the provider.**

Fayetteville Technical Community College requires that employees requesting disability accommodations provide current medical documentation of their physical or mental impairment. The purpose of this form is to assist the College in determining whether an employee has a disability as defined by the Americans with Disabilities Act (ADA) and amendments. If yes, this information will assist in determining if a reasonable accommodation is available 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 fully complete all sections and provide a brief narrative where applicable. Please review the attached job description prior to completing this form.

**Employee Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | | |  | |
| Department: | |  | | Position Title: |  |
| Current Work Schedule: | | |  | | |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Diagnosis: |  | |  |  |
|  | | | | |
| Diagnosis: |  | | | |
|  | | | | |
|  | | | | |
|  |  | | | |
| History of Diagnosis: | |  | | |
|  | | | | |
| Nature & Severity: | |  | | |
|  | | | | |
|  | | | | |
| Temporary or Long-term: | |  | | |
| If Temporary, Duration: | |  | | |

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

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| --- | --- | --- | --- | --- |
| Date of Diagnosis: |  | |  |  |
|  | | | | |
| Diagnosis: |  | | | |
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|  | | | | |
| History of Diagnosis: | |  | | |
|  | | | | |
| Nature & Severity: | |  | | |
|  | | | | |
|  | | | | |
| Temporary or Long-term: | |  | | |
| If Temporary, Duration: | |  | | |

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| How does the impairment in its corrected or medicated condition, affect the employee in the activities required in the workplace? |
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**Employee’s Affected Major Life Activities:**

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

**Employee’s Affected Major Bodily Functions:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Immune System |  |  | Digestive, Bowel, Bladder |
|  | Endocrine |  |  | Neurological, Brain |
|  | Respiratory |  |  | Circulatory |

**Substantial and/or Significant Restrictions or Limitations:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please describe how the employee’s physical or mental impairment substantially or significantly restricts his/her ability to perform workplace activities: | | | | |
|  | | | | |
| **Restrictions or Limitations** |  | **Frequency/Duration** |  | **Severity (Mild/Moderate/Severe)** |
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**Accommodations**:

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| --- |
| Please describe any accommodations he/she 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: |  |

**RETURNED COMPLETED FORM TO:**

Vice President for Human Resources

Fayetteville Technical Community College

Thomas R. McLean Administration Bldg. Room 162

2201 Hull Road

Fayetteville, NC 28303

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