DOCUMENTATION OF DISABILITY FORM

This form is for the Office of Institutional Equity (OIE), to determine whether an employee qualifies under the Americans with Disabilities Act (ADA), the ADA Amendments Act of 2008 (ADAAA).

Section 1: To be completed by employee:

_____ _____
Employee's Name Job Title

_____ _____
Department of Employment Supervisor

Release of Information:
I hereby authorize the release of information provided by my physician, or care provider, in Section 2 (below) to Western Kentucky University (WKU) for the purpose of determining availability of reasonable workplace accommodations. I further authorize WKU to seek clarification of this documentation, if necessary, by contacting my physician, or care provider, and I authorize my physician, or care provider, to respond to such requests for clarification.

_____ (Employee's Signature) _____Date

Treating Professional's Contact Information:

_____ (Name)

_____ (Street Address)

_____ (City/State/Zip Code)

_____ (Phone No.)

Section 2: To be completed by the physician, or care provider:
Please answer and return the following form to OIE within the time frame indicated. The questionnaire format is a guide, and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions, if needed, to answer more fully. Thank you for your anticipated cooperation.

IMPORTANT NOTE TO HEALTH CARE PROVIDER:

When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics, including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

1. Does the individual have a current disability? Yes □ No □
   (According to the ADA, a "person with a disability" is defined as anyone with a physical or mental impairment that substantially limits one or more major life activities.)

   a. If yes, what specifically is the diagnosis/condition?

   b. What is the nature of the condition?

2. Is this a medical, psychological, or physical condition that affects a major life activity?
   Yes □ No □ ***(Check all of the following that apply).***

☐	Walking	☐	Speaking	☐	Breathing
☐	Hearing	☐	Seeing	☐	Concentration
☐	Working	☐	Standing	☐	Reaching
☐	Sleeping	☐	Learning	☐	Lifting
☐	Memory	☐	Thinking	☐	Sitting
☐	Performing Manual Tasks	☐	Caring for Oneself	☐	Interacting with Others
☐	Major Bodily Functions	☐	Other		

3. Additional life activities affected:

4. Does this employee's condition **substantially** limit the major life activity listed above?
   Yes □ No □

   a. How is the individual substantially limited in the major life activity identified above?

b. Discuss evidence of the disability:

c. What is the severity?

d. Please list any prescribed medication(s) that control(s) all or some of the symptoms?

e. Are there impacts or side effects from the medication(s)?

Yes □ No □

If so, what are they?

f. What is the expected duration and long-term impact(s) of this condition?

g. Is this a chronic or episodic disability that is substantially limiting when active?

Yes □ No □

If yes, please explain.

5. List appropriate accommodations you recommend for this individual.

6. Additional notes or comments:

Treating Professional's Name: _____
(Please Print)

Signature: _____ Date: _____/_____/_____

Name of Practice: _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____

Email: _____

PLEASE EMAIL OR FAX THIS COMPLETED FORM TO THE FOLLOWING DEPARTMENT:

Office of Institutional Equity
1906 College Heights Blvd. #11009
Bowling Green, KY 42101
Phone: 270-745-5121 Fax: 270-745-3199
Email: chantel.gillenwater@wku.ed