**DOCUMENTATION OF DISABILITY FORM**

**TO BE COMPLETED BY A PHYSICIAN OR QUALIFIED HEALTH CARE PROFESSIONAL**

The Human Resources Office requires that employees requesting an accommodation provide current documentation about their physical or mental impairment. Eligibility is based on documented clinical data, not just self-report or evidence of diagnosis. The purpose of this form is to assist the University of Wisconsin - Green Bay in determining whether or not an employee has a disability as defined by the Americans with Disabilities Act (ADA); and if yes, whether or not a reasonable accommodation can be granted 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 complete fully all sections and provide a brief narrative where applicable. Please review the job description or classification specifications prior to completing this form.

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| **EMPLOYEE INFORMATION** |
| Employee Name: |  |  | Department: |  |
| UW System Title: |  |  | FTE %: |  |
| Working Title: |  |  | Supervisor: |  |
|  |
| **PRIMARY DIAGNOSIS** |
| Diagnosis:  |  | Date of Diagnosis: |  |
|  |
| History of Diagnosis:  |
|  |
| Nature & Severity:  |
|  |
| Temporary or Long-Term: |  |
|  If temporary, duration: |  |
|  |
| **OTHER DIAGNOSIS (MUST BE CURRENT)** |
| Diagnosis:  |  | Date of Diagnosis: |  |
|  |
| History of Diagnosis:  |
|  |
| Nature & Severity:  |
|  |
| Temporary or Long-Term: |  |
|  If temporary, duration: |  |
|  |
| **OTHER**  |
| Major life activities affected:  |
|  |
| Major bodily functions affected: |
|  |
| Please describe how the diagnosis substantially or significantly restricts his/her ability to perform workplace activities:  |
|  | Restriction or Limitation | Frequency/Duration | Severity (Mild, Moderate, etc.) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **ACCOMODATIONS** |
| Please describe any accommodations he/she may require to perform job functions safely and effectively:  |
|  |
| **HEALTHCARE PROVIDER INFORMATION** |
| Name:  |  |
| Title:  |  |
| Hospital/Practice:  |  |
| Address:  |  |
| City, State, ZIP: |  |
| Phone Number:  |  |
| Signature:  |  | Date:  |  |
|  |
| **PROVIDER** |
| Please return documentation to fax number or address below. |