



HUMAN RESOURCES /
AFFIRMATIVE ACTION OFFICE

2420 NICOLET DRIVE

T 920-465-2390

GREEN BAY, WI 54311-7001

F 920-465-5104

www.uwgb.edu/hr/policies/AEEO/

Documentation of Disability Form

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

IMPORTANT: Please Enclose Job Description/Classification Specifications for Your Provider!

The Human Resources/Affirmative Action 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.

Employee Information:

Name: _____

Department/Unit: _____ Position/Title: _____

Primary Diagnosis: (Must be *current*)

Date of Diagnosis: _____

Diagnosis: _____

History of Diagnosis: _____

Nature & Severity: _____

Temporary or Long-term: _____

If Temporary, Duration: _____

Other Diagnosis: (Must be *current*)

Date of Diagnosis: _____

Diagnosis: _____

History of Diagnosis: _____

Nature & Severity: _____

Temporary or Long-term: _____

If Temporary, Duration: _____

Please Describe the Employee's Affected Major Life Activities:

Employee's Affected Major Bodily Functions:

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)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Accommodations:

Please describe any accommodations he/she may require to perform job functions safely and effectively:

Physician/Health Care Provider Information:

Name and Title: _____

Name of Hospital/Practice: _____

Address: _____

Telephone: _____

Signature & Date: _____

THIS FORM SHOULD BE RETURNED DIRECTLY TO:

Human Resources
University of Wisconsin – Green Bay
2420 Nicolet Drive
Green Bay, WI 54311-7001