



Employee Disability Verification Form

It is the policy of Auburn University, at all levels, to employ, to advance in employment, and to treat otherwise qualified employees and applicants with disabilities without discrimination. Where an employee is determined to have an ADA-qualifying disability, reasonable workplace accommodations will be made.

(To be completed by Employee)

<p>I, _____, authorize my physician (Employee name – please print)</p> <p>_____ or any of the employees or agents (Physician’s name)</p> <p>Of _____ to provide medical (Name of practice)</p> <p>information and answer questions regarding my condition to the University, in order to determine my eligibility for services.</p> <p>Employee’s Signature _____ Date _____ Banner ID# _____</p>

(To be completed by Physician)

Important Note to Treating Physician: The above- named employee is requesting reasonable workplace accommodations for a disability. We appreciate your cooperation in providing the following information, at the employee’s request. This information will be maintained in a separate location from the employee’s personnel file in the ADA Office, and its contents shared only on a need-to-know basis only. Complete only those sections you feel are applicable to this patient’s request for workplace accommodations.

Physician’s name (print): _____ Specialty _____

Address _____ City _____ ST _____ Zip _____

Phone (____) _____ FAX (____) _____ E-mail _____

Date of last appointment: _____ Next Appointment: _____

Diagnosis: _____

Recurring or Episodic Symptoms (please describe your opinion of the frequency, severity, and approximate anticipated duration of the symptoms):

Pg. 2 Disability documentation for Employee/Patient Name: _____

Anticipated duration of condition: _____

Which word best describes the nature of this medical condition? Chronic Temporary Permanent

Limitations experienced by the patient/employee on an ongoing basis (as a result of the condition and treatment you administered): _____

Please list any limitations that you anticipate will be need to be addressed on an ongoing basis with respect to the work to be performed by the patient/employee, and the predicted length of time they may be needed. (If the employee's job description is not attached and one is needed for reference, please contact the ADA Office for Employees at 334.844.4794 or by fax to 334.844.4793.): _____

Suggestions/Comments by Physician:

With my signature, I certify that the above information is true, accurate to the best of my medical certainty, and documented as part of the patient's medical record.

Physician's Signature _____ **Date** _____

Please return this information by FAX (334-844-4793) or mail to: Auburn University AA/EEO and ADA Office, James E. Foy Hall, Auburn University, Alabama 36849. Call 334.844.4794 if you have any questions. Thank you.