EMPLOYEE: Release of Information

I, _____, hereby authorize the release of the following information to the ADA Coordinator for the purpose of determining my eligibility as a person with a disability on the campus of Fayetteville State University.

Signature: _____ Date: _____

TO THE DIAGNOSING PROFESSIONAL:

Employees requesting a disability eligibility review for the purpose of receiving accommodations at Fayetteville State University are required to provide current documentation about their physical or mental impairment. Documentation standards to determine legal eligibility are more stringent than for usual clinical practice. Eligibility is based on documented clinical data not simply on self-report or evidence of a diagnosis. The university's ADA Coordinator will review the documentation you provide. The purpose of the review is to determine whether or not the employee has a "disability," as defined by the Americans with Disabilities Act (ADA) of 1990. The definition of "disability" as outlined in this Act, is tailored for the purpose of eliminating discrimination, and therefore, may differ from the definition of "disability" under other statutes. As the diagnosing professional, please complete fully all sections of this form and provide a brief narrative. Failure to do either may interfere with the employee receiving a timely eligibility decision.

Documentation should be sent directly to:

ADA Coordinator/Human Resources
Fayetteville State University
1200 Murchison Road
Fayetteville, NC 28301
FAX: 910-672-1821

PLEASE NOTE: ALL INFORMATION PROVIDED MIGHT BE SHARED WITH THIS EMPLOYEE UNLESS CLEARLY MARKED OTHERWISE.

For purposes of the ADA, a diagnosing professional must provide clear and precise documentation that allows the ADA Coordinator to answer the following question as part of a **3-Step Inquiry**:

Documentation of Disability Form

THE 3-STEP INQUIRY

STEP 1: Information regarding the employee's physical or mental impairment

Attach any test results or reports that support the following information.

***Primary diagnosis*: _____**

Date of diagnosis: _____ History of impairment: _____

_____

_____

Nature and severity: _____

Is the impairment persistent and long-term? _____

If the impairment is temporary, what is the expected duration? _____

***Secondary diagnosis*: _____**

Date of diagnosis: _____ History of impairment: _____

_____

_____

Nature and severity: _____

Is the impairment persistent and long-term? _____

If the impairment is temporary, what is the expected duration? _____

***Other diagnosis*: _____**

Date of diagnosis: _____ History of impairment: _____

_____

_____

Nature and severity: _____

Is the impairment persistent and long-term? _____

If the impairment is temporary, what is the expected duration? _____

Date of last visit: _____ How often do you provide treatment?

_____

Describe the medications and/or other corrective measures that have been prescribed and any possible side effects: _____

_____

STEP 2: Information regarding the employee's affected major life activity

Which, if any, of the major life activities, does the physical or mental impairment/s affect?

Please check all that apply:

☐ **Breathing** ☐ **Learning** ☐ **Walking**
☐ **Caring for self** ☐ **Performing manual tasks** ☐ **Working*****_____
☐ **Hearing** ☐ **Seeing** ☐ **None**

***** If you checked "working" as the affected major life activity, please provide more detailed information by checking all components of "working" that are substantially affected:**

☐ **Fulfilling key job responsibilities**
☐ **Performing at an acceptable level**
☐ **Demonstrating workplace knowledge/skills**
☐ **Acquiring new workplace knowledge/skills**
☐ **Judgment and use of appropriate occupational behaviors**
☐ **Communicating** ☐ **verbal** ☐ **written**
☐ **Developing/maintaining working relationships**
☐ **Attending regularly**
☐ **Organizing effectively and efficiently**
☐ **Leading others**
☐ **Complying with safety and health requirements**

STEP 3: Information regarding the employee's substantial limitations

Information is needed about how the employee is ***significantly*** restricted in comparison to the average person in the general population as to the conditions, manner, or duration under which activities can be performed. How does the physical or mental impairment, in its corrected or medicated condition, affect the employee in the activities required in the workplace? List the following: the specific ***substantial functional limitations***, how often they occur, how long they last, and the severity of each.

Limitations Frequency/Duration Severity
(daily, weekly, etc./# hours, days, etc.) (mild, moderate, severe)

Are there any activities or situations that should be avoided by this employee or would present a significant risk of serious injury or death for this employee or others?

_____

_____

Which accommodations, if any, do you recommend? (This is for informational purposes only. If required, Fayetteville State University will determine the appropriate, reasonable accommodations.) _____

_____

WRITTEN NARRATIVE

A written narrative, signed, dated, and on letterhead, must be submitted with this form. The narrative can be brief, but must include:

1. a specific, current diagnosis (within one year),
2. what procedures were used to diagnose the impairment,
3. a description of the limitations the employee currently experiences in the workplace,
4. whether or not accommodations will be needed when utilizing medications and/or corrective measures.[i]

MEDICAL OFFICIAL:

Name/Title: _____

Business address: _____

Phone: _____**Fax:** _____ **Email:** _____

Professional Credentials: _____ **License/Certification #:** _____

Area of Specialization: _____ **State/Province** _____

Signature: _____ **Date** _____