## EMPLOYEE DISABILITY VERIFICATION FORM

In order to determine your eligibility to receive an accommodation, the Office of Human Resources requires specific information from both you and your health care provider. Please sign the Authorization to Release Information below giving Human Resources permission to speak with your provider if there are questions related to your documentation. You must complete page 1, and your provider must complete pages 2-4. This verification form (pages 1-4) should be returned to the Office of Human Resources.

<b>Employee Completes This Section (Please Print or Type):</b>				
Name:				
(Last)	(First)	(Middle)		
Social Security Number:				
Home Address:				
Home Phone #:				
Resources at Lewis & Clark C authorize a representative from authorize my provider to disco Resources. I understand the r functional abilities and limitat	CLEASE INFORMATION: I authorical College to receive information from the man the Office of Human Resources to cluss my condition(s) with a representate eason for this contact is to advise Lewitions in relation to my job functions. The analysis and inquiries will be maintained are ments.	e provider below. I also contact my provider. I ive from the Office of Huma vis & Clark College about my All information obtained from		
Name of Provider:				
Address (Street, City, State, a	nd Zip):			
Phone Number		_		
Employee's Signature:		Date:		

EMPLOYEE'S NAME:
Provider Completes the Section Below:
Lewis & Clark College provides reasonable accommodations to employees who meet the requirements under the Americans with Disabilities Act (ADA; 1990). An employee's documentation regarding his/her condition must describe a disability covered under the ADA. *The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. To determine eligibility for services and accommodations, this office requires current and comprehensive documentation of the employee's disability from the diagnosing physician or health care provider. Items 1 thru 6 must be completed in full. If space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.
Please respond to the following items regarding the employee named above (Please Print or Type):
1. What is the employee's medical condition/diagnosis?
a. How long has the employee had this condition?
b. What is the severity of the condition?
c. How long is this condition likely to persist?

2. Describe the symptoms related to the employee's condition that cause significant impairment in a major life activity (e.g. working, walking, seeing, hearing etc.)
3. List this employee's current medication(s), dosage, frequency, and adverse side effects (If applicable for the above-mentioned diagnosis).
a) Are there significant limitations to the employee's functioning directly related to the prescribed medications?  Yes No
b) If yes, please describe.
4. Does the employee have a *disability (as described on page 2) as a result of this condition?
Yes No Not Sure

5. If yes, please state specific recommendations re and a rationale as to why these accommodations are functional limitations. Indicate why the accommodations	e warranted based upon the	employee's
6. If current treatments (e.g., medications) are sucnecessary?	ecessful, why are the above	accommodations
The provider may also send a report that provider the provider completing this form cannot be a		rmation.
Signature of Provider:	Date:	
License #	State	
(Please Type or Print)		
Name/Title:		
Address:		
Phone:		
Thank you! Please return this form to: Human Resources Lewis & Clark College	Phone:	

Revised 12/02