

INDIANA STATE UNIVERSITY

Office of Affirmative Action

Parsons Hall, Suite 223
Terre Haute, IN 47809

Telephone: (812) 237-8954
Fax: (812) 237-8960

DISABILITY DOCUMENTATION FORM

It is the policy of Indiana State University to make reasonable accommodations to the physical and mental limitations of an employee or applicant unless such an accommodation would impose an undue hardship on the University. Upon voluntary identification, persons with disabilities will be given an opportunity to describe any special methods, skills, and procedures that qualify the person for positions that otherwise would present difficulties because of a disability and the accommodations that the employing department might make that would enable a person with a disability to perform the job properly and safely, including special equipment, changes in the physical layout of the job, elimination of certain duties relating to the job, or other accommodations.

Instructions

To the person completing this form:

This form is to be completed when (1) An employee or individual requests an accommodation or, (2) when it is apparent that a reasonable accommodation may enable an individual with an obvious disability to either better perform the essential functions of a currently held position. The completed form will be kept on file in the Office of Affirmative Action.

I authorize the release of information below to Indiana State University, Office of Affirmative Action and ADA Compliance Committee for purposes of evaluating my request for accommodation using the following information. This authorization will remain in force until revoked in writing.

Signature: _____ Date: _____

Requested Accommodation:

Dear 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.

Date: _____

Physician's Name (print) _____ Specialty _____

Address _____ City _____ ST _____ Zip _____

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

Date of Last Appointment _____ Next Appointment _____

Diagnosis: _____

Nature of Disability: _____

Symptoms _____

Employee may perform the functions of the attached job description with no restrictions. Yes _____ No _____

If no, please check the following physical limitations or items that apply to this employee:

- 1. Seated work only
- 2. No pushing, pulling or lifting over _____ pounds
- 3. No repeated bending or cramped positions
- 4. No prolonged kneeling or squatting
- 5. No kneeling or squatting
- 6. No continuous walking
- 7. No walking up any steps
- 8. No walking up steps other than to work level
- 9. No continuous standing
- 10. No work on ladders or overhead
- 11. No work with arms above shoulder level
- 12. No exposure to dust including buffing of metals or plastics
- 13. No exposure to chemical fumes/vapors
- 14. Accurate far vision
- 15. Accurate near vision
- 16. True color perception
- 17. True depth perception
- 18. No squeezing of hand tools
- 19. Good hearing
- 20. No exposure to excessive noise
- 21. No work around moving machinery
- 22. No operation of moving machinery
- 23. No operation of motor vehicle
- 24. No use of vibratory tools
- 25. No finger dexterity
- 26. Exposure to solvents, greases, thinners, or sealers
- 27. Exposure to oils, resins, or fiberglass
- 28. Bicycle riding
- 29. Any industrial type of physical activity
- 30. Altitude over _____
- 31. Anything other than seated work
- 32. Other _____
(Please list)

Frequency of symptoms (hourly _____ daily _____ weekly _____ monthly _____ yearly _____ very seldom _____)
 Anticipated duration of condition, from _____ to _____ Chronic? _____ Temporary? _____ Permanent? _____
 Severity of condition/symptoms (none _____ mild _____ moderate _____ mod-severe _____ severe _____)

Please review the above accommodation request by the employee. In your medical opinion, what is the best accommodation that can be made for this employee?

Are there any alternative means of accommodating this employee? Please list

Comments: _____

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

Physician's Signature _____ Date _____

Please return this form by FAX (812) 237-8960 or mail to: Office of Affirmative Action, Parsons Hall, Suite 223, Indiana State University, Terre Haute, Indiana, 47809. Call (812) 237-8954 if you have any questions. Thank you.