

**Office of Institutional Access and Equity  
Southern Methodist University**

**Employee Documentation of Disability Form**

**Employee Section**

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**Employee Instructions:** Please complete the Employee Section of this form and submit it to your physician. Please inform your physician of the essential functions of your position and your request for a reasonable accommodation. To initiate a request for reasonable accommodation, please submit the completed Employee Documentation of Disability Form and the [Employee Reasonable Accommodation Request Form](#) to the ADA/504 Coordinator in the Office of Institutional Access and Equity. These confidential forms will not be placed in your personnel file and will be maintained in the Office of Institutional Access and Equity.

**Authorization and Release of Information:**

I, \_\_\_\_\_, hereby authorize my physician to release to and discuss with the Office of Institutional Access and Equity any and all information related to my impairment that may be required to properly assess my request for a reasonable accommodation. I further authorize the Office of Institutional Access and Equity to seek clarification of this documentation by contacting my physician.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician Section**

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**Physician Instructions:** To request a reasonable accommodation, an employee must provide current documentation of a disability. Federal law defines a disability as a physical or mental impairment that substantially limits a major life activity, a record of such an impairment, or being regarded as having such an impairment. As the employee's physician, please complete all sections of this form and attach additional information if needed. Please return the form to the employee or directly to the Office of Institutional Access and Equity, Southern Methodist University, P.O. Box 750200, Dallas, TX 75275-0200, or by Fax to 214-768-2101. Please feel free to contact us at 214-768-3601 if you have any questions. Thank you for your assistance.

Please identify and describe the nature and severity of the employee's physical or mental impairment:

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What is the duration of the impairment? \_\_\_\_\_

Please describe how the impairment substantially limits a major life activity (e.g., walking, breathing, hearing, speaking, seeing, learning, performing manual tasks, or others):

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Please describe how the impairment impacts the essential functions of the employee's position:

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Please identify any accommodations that could assist the employee in performing the essential functions:

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Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

License Number: \_\_\_\_\_ State: \_\_\_\_\_

Type of Practice: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_