Office of Equal Opporunity
Southern Methodist University

Employee Documentation of Disability Form

Employee Section

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 by submitting a copy of the Employee Reasonable Accommodation Request Form and/or Job Evaluation Form to your physician. After your physician completes the Employee Documentation of Disability Form, please submit it and the Employee Reasonable Accommodation Request Form to the ADA/504 Coordinator in the Office of Equal Opportunity to initiate a request for a reasonable accommodation. These confidential forms will not be placed in your personnel file and will be maintained in the Office of Equal Opportunity.

Authorization and Release of Information:

I, _____, hereby authorize my physician to release to and discuss with the Office of Equal Opportunity 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 Equal Opportunity to seek clarification of this documentation by contacting my physician.

Employee Signature: _____ Date: _____

Physician Section

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 Equal Opportunity, 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 (physiological or psychological disorder):

_____

_____

_____

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, eating, sleeping, thinking, performing manual tasks, lifting, major bodily functions):

_____

_____

_____

Please describe any medications and/or corrective measures that have been prescribed or recommended and their effect:

_____

_____

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

_____

_____

_____

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

_____

_____

_____

Physician's Name: _____ Phone: _____

Fax: _____ License Number: _____ State: _____

Type of Practice: _____ Email: _____

Address: _____

_____

Physician's Signature: _____ Date: _____