DOCUMENTATION OF DISABILITY

Section 1: To be completed by employee:

_______________________________	___________________________
Employee name	Job Title
_______________________________	___________________________
Department	Supervisor

Release of Information:

I hereby authorize the release of the information provided by my physician or care provider in section 2 below to Goucher College for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Goucher College to seek clarification of this documentation, if necessary, by contacting my physician or care provider and I authorize my physician or care provider to respond to such requests for clarification.

_____________________________ (Employee Signature)

Section 2: To be completed by the physician or care provider:

Please answer and return the following form to the Goucher College Department of Human Resources within the time frame indicated. The questionnaire format is a guide and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions if needed to answer more fully. Thank you for your anticipated cooperation.

IMPORTANT NOTE TO HEALTH CARE PROVIDER: When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics, including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

PLEASE MAIL OR FAX THE COMPLETED FORM TO (please notify us in advance if you are faxing this information and include a confidential cover page):

Goucher College
Department of Human Resources
1021 Dulaney Valley Road
Baltimore, MD 21204
Phone: 410-337-6135
Fax: 410-337-6236

1. Does the patient have a physical or mental impairment? Yes ___ No ___

If so, please state the type of impairment:
____
____
____
____

2. Does the patient's impairment substantially limit any major life activities[1]?

Yes ___ No ____

3. If so, which major life activity or activities are limited?

____
____
____
____

4. For each major life activity that is limited by the impairment, please describe how the patient is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way in which an average person in the general population can perform that activity:

____

____

____

____

5. What is the duration or expected duration of the patient's impairment?
____

____

6. Attached is a job description for the patient's position. Please review the essential job description and assess whether the patient can perform all essential job functions: Yes ______ No _______

[1] "Major life activities" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working, and the operation of major bodily functions, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

7. If not, which essential job functions cannot be performed, and why not?

____

____

8. Please describe any reasonable accommodations that would allow this employee to be able to perform those job functions and state why such accommodations are necessary:

____

____

9. Would performing any of the job functions listed result in a direct safety or health threat to this employee or other people (co-workers, members of the general public, etc.)?

Yes _______ No ________

11. If yes, please describe:

- Which job functions would pose such a threat: __________________________

____

- The direct safety or health threat posed:________________________________

____

- Any reasonable accommodations that would eliminate the direct safety or health threat, or reduce it to an acceptable level:________________________________

____

_________________________ ____________________
Signature Title

Name and Address (Printed):

____
____
____

Date:____________________________