Disability Documentation & Accommodation Request Form

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee’s Name: ____________________________________________

**Directions: This page is to be completed by the Health Care Professional.**

### Determining Disability

<table>
<thead>
<tr>
<th>Does the employee have a physical or mental impairment?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the impairment (please include the medically recognized diagnosis)?</td>
<td>______________________________________</td>
</tr>
<tr>
<td>Date of most current diagnosis</td>
<td>______________________________________</td>
</tr>
<tr>
<td>Is the impairment permanent, long-term, or chronic?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>If not, what is the expected duration of the impairment?</td>
<td>______________________________________</td>
</tr>
<tr>
<td>Please describe the expected progression or stability of the impact of the disability over time.</td>
<td>______________________________________</td>
</tr>
</tbody>
</table>

| Does the impairment affect a major life activity? | Yes ☐ No ☐ |
| If yes, please indicate the major life activity(s) affected (i.e. breathing, caring for self, hearing, seeing, thinking, or walking). | ______________________________________ |

### Additional Pertinent Information

Please include any other information to assist this employee. ______________________________________

Health Care Professional Signature ___________________________ Date __________
Directions: This section is to be completed by the employee and Health Care Professional

Determining Accommodations

How does the employee's limitation interfere with the ability to perform the job function(s)?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

What accommodations would assist the employee in performing the job function(s)?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

How would the recommended accommodations alleviate the effect of the disability on the employee's job performance?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Health Care Professional Credentials/License

Please list your credentials/license that relate to the diagnosis.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Additional Pertinent Information

Please include any other relevant information.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Health Care Professional Signature ____________________________ Date ______

Employee Signature ____________________________ Date ______

This document is available in alternative formats upon request by contacting Ed Rowe in Office of Equity, Inclusion and Compliance at: (561) 297-3004 or growe@fau.edu