

## Documentation of Disability

### To Iowa State University Employee:

To make a request for accommodation, an employee must:

- Complete and submit the [Employee Disability Accommodation Request](#) to his or her supervisor.
- Complete Section 1 below and have the physician or care provider complete Section 2 and submit the **Documentation of Disability** form to *Duane Reitz, Human Resource Services, 3680 Beardshear, Ames, IA 50011* or via facsimile at 515/ 294-7530. Questions may be directed to Duane Reitz at 515/ 294-7083 or [workerscomp@iastate.edu](mailto:workerscomp@iastate.edu).
- Provide a copy of the employee's job description to the physician or care provider. The employee's supervisor or Duane Reitz, Human Resource Services, can assist the employee.

The [Disability Accommodation Request](#) and Documentation of Disability forms are necessary to initiate a request for accommodation—available online at:

<http://www.hrs.iastate.edu/AAO/eod/reasonaccom.shtml>. If, after receiving all of the documentation, ISU concludes the employee is eligible the department will consider what reasonable accommodations are possible under the circumstances. When a department is able, it may consult with Human Resource Services Employee Relations Office to make job modifications to assist an employee even if the condition is not a disability. Making such modifications does not mean the employee is considered disabled.

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**Section 1: To be completed by employee:**

\_\_\_\_\_  
Employee name

\_\_\_\_\_  
Job Title

\_\_\_\_\_  
Department

\_\_\_\_\_  
Supervisor

### Release of Information

I hereby authorize the release of the following information to Iowa State University for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Iowa State University to seek clarification of this documentation if necessary by contacting my physician or care provider.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date

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

### To Physician or Care Provider:

To request reasonable and appropriate accommodations, employees must provide current documentation of a disability. Federal and state law define a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment. As the employee's physician or care provider, you are asked to fully complete all sections of this form. Additional information can be attached if necessary.

To complete this form (see attached, Page 2, Section 2), you must review the employee's job description and other information relevant to the employee's job at Iowa State University. If those materials have not been provided, please contact the employee and let him or her know you cannot complete this form without those materials. Thank you for your assistance.

**Page 2, Section 2 Employee Name** \_\_\_\_\_

1. Please identify the employee's physical or mental impairment:

\_\_\_\_\_  
\_\_\_\_\_

- Please describe the duration of this impairment (e.g., long-term, permanent, recent, short-term). \_\_\_\_\_

\_\_\_\_\_

2. Please describe the effects or limitations this impairment has on the employee's activities, if any.

\_\_\_\_\_  
\_\_\_\_\_

- Please describe whether medication and/or corrective measures have been prescribed or recommended that may reduce or eliminate any of these limitations. \_\_\_\_\_

\_\_\_\_\_

3. By reviewing the attached information concerning the employee's job duties, please describe the effect or limitations this impairment has on the employee's ability to perform the job duties, if any.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Are there any activities or situations that should be avoided or that would present a health or safety risk to the employee or others due to the impairment? \_\_\_\_\_

\_\_\_\_\_

4. Please offer any suggested accommodations that might enable the employee to perform his or her job duties.

- \_\_\_\_\_ Duration? \_\_\_\_\_

- \_\_\_\_\_ Duration? \_\_\_\_\_

- \_\_\_\_\_ Duration? \_\_\_\_\_

**Thank you for your assistance in providing this information so that we may assess the employee's request. Please sign below.**

\_\_\_\_\_  
**Signature of physician or care provider**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Provider name (printed)**