UNCG Human Resources
723 Kenilworth Street
PO BOX 26170
Greensboro, NC 27402
T 336-334-5009
F 336-334-5585

Documentation of Disability Form

TO BE COMPLETED BY A PHYSICIAN OR QUALIFIED HEALTH CARE PROFESSIONAL

IMPORTANT: Please Enclose Job Description/Classification Specifications for Your Provider!

The Human Resources Office requires that employees requesting an accommodation provide current documentation about their physical or mental impairment. Eligibility is based on documented clinical data, not just self-report or evidence of diagnosis. The purpose of this form is to assist the University of North Carolina at Greensboro in determining whether, or not an employee has a disability as defined by the Americans with Disabilities Act (ADA); and if yes, whether or not a reasonable accommodation can be granted to assist the employee in performing one or more essential functions of his or her job safely and effectively. As the diagnosing professional, we ask that you complete fully all sections and provide a brief narrative where applicable. Please review the job description or classification specification prior to completing this form.

Employee Information:

Name: _____ Gender: ☐ Male ☐ Female

Department/Unit: _____ Position/Title: _____

Current Work Schedule/Shift: _____

Primary Diagnosis: (Must be ***current***; please attach any related test results.)

Date of Diagnosis: _____

Diagnosis: _____

_____

_____

History of Diagnosis: _____

Nature & Severity: _____

_____

Temporary or Long-term: _____

If Temporary, Duration: _____

Other Diagnosis: (Must be ***current***; please attach any related test results.)

Date of Diagnosis: _____

Diagnosis: _____

_____

_____

History of Diagnosis: _____

Nature & Severity: _____

_____

Temporary or Long-term: _____

If Temporary, Duration: _____

Employee's Affected Major Life Activities:

- ☐ Seeing
- ☐ Hearing
- ☐ Speaking, Communicating
- ☐ Eating
- ☐ Sleeping
- ☐ Working**
- ☐ Walking, Standing, Lifting, Bending
- ☐ Breathing
- ☐ Performing Manual Tasks
- ☐ Learning, Reading, Concentrating, Thinking
- ☐ Caring for Self
- ☐ None

Employee's Affected Major Bodily Functions:

- ☐ Immune System
- ☐ Endocrine
- ☐ Respiratory
- ☐ None
- ☐ Digestive, Bowel, Bladder
- ☐ Neurological, Brain
- ☐ Circulatory

Substantial and/or Significant Restrictions or Limitations:

** Please describe how the employee's physical or mental impairment substantially or significantly restricts his/her ability to perform workplace activities:

Restrictions or Limitations	**Frequency/Duration**	**Severity (Mild/Moderate/Severe)**

Accommodations:

Please describe any accommodations he/she may require to perform job functions safely and effectively:

_____

_____

_____

_____

Physician/Health Care Provider Information:

Name and Title: _____

Name of Hospital/Practice: _____

Address: _____

Telephone: _____

Signature & Date: _____

THIS FORM SHOULD BE RETURNED DIRECTLY TO:

UNCG Human Resources
EEO & Affirmative Action
Patricia Lynch, Director of ER and EEO/Affirmative Action
MaLinda Gonzalez, EEO Consultant/Investigator
723 Kenilworth Street
PO Box 26170
Greensboro, NC 27402
Fax: 336-334-5585

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Accommodation Request Form

The University of North Carolina at Greensboro is committed to equal opportunity in all aspects of employment for qualified disabled individuals. The purpose of this form is to assist the University of North Carolina at Greensboro in determining whether, or to what extent, a reasonable accommodation is necessary for an employee with a disability to perform one or more essential functions of his or her job safely and effectively.

The information you provide will be kept confidential consistent with State and Federal law. Please note that supervisors and managers may be informed regarding necessary accommodations; health and safety personnel may be informed if the condition might require emergency treatment; and government officials investigating compliance with applicable laws may be informed.

This form must be filed *in addition to* the Self-Identification of Disability form.

Employee Information:

Name: _____ Gender: ☐ Male ☐ Female

Department/Unit: _____ Position/Title: _____

Employment Status: ☐ EHRA ☐ SHRA ☐ Student Employee ☐ Permanent ☐ Temporary

Phone # (Work): _____ PID #: _____

Phone # (Home/Cell): _____ Email Address: _____

Mailing Address (Please include CB# if office address): _____

_____

_____

Supervisor: _____ Phone #: _____

HR Representative: MaLinda Gonzalez, EEO Consultant (336) 334-9751

Phone #: Current Work Schedule/Shift: _____

Former/Existing Accommodations: _____

_____

University Offices Contacted: _____

_____

Date of Hire: _____

Disability Information:

1. Please indicate the nature of your disability:

☐ Visual Impairment	☐ Nervous System/Neurological Disorder
☐ Hearing Impairment	☐ Mental/Psychological Impairment
☐ Mobility Impairment	☐ Learning Disability
☐ Respiratory Impairment	☐ Other (Please Describe)
☐ Speech Impairment	

2. Is your disability:

☐ Temporary (If so, how long?) _____

☐ Permanent _____

3. Please briefly describe any limitations or restrictions caused by your disability:

_____

_____

_____

_____

4. Please list any accommodation(s) or service(s) related to your disability that would help you to meet the essential functions of your current job:

_____

_____

_____

_____

I hereby agree that the UNCG Human Resource Office is permitted to share relevant information from my physician or other health care provider(s) with the supervisor(s) in my immediate work unit and other University offices that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work related responsibilities.

I also agree that the HR Office has my permission to contact my physician or other health care provider(s) for additional information to assist in developing reasonable accommodations for me.

I understand that I must also submit the **"Documentation of Disability"** form signed by an authorized physician or other health care provider. This form should include a description of my disability; any related limitations; and recommendations for accommodation(s) and/or service(s).

_____ _____

Print Name Signature

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Health Care Provider – Medical Information Release Form

I, _____, voluntarily give the University of North Carolina at Greensboro, Equal Opportunity and Compliance Office permission to contact my physician(s) and/or healthcare provider(s) as listed below to obtain information related to my disability; any related limitations; and recommendations on necessary accommodations.

Name of Physician/Health Care Provider _____

Name of Hospital/Practice _____

Address _____

Telephone # _____

Name of Physician/Health Care Provider _____

Name of Hospital/Practice _____

Address _____

Telephone # _____

I have been given an opportunity to ask questions about this form and to have them answered to my satisfaction. I further understand that relevant information obtained may be shared with the supervisor(s) in my immediate work unit and other University offices that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work related responsibilities.

_____

Name

_____ _____

Signature Date

The University of North Carolina at Greensboro is an Equal Opportunity Employer that welcomes all, including protected veterans and individuals with disabilities.

Last Updated 02-17-2021

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: Date:
Employee ID:
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- ☐ Yes, I have a disability, or have had one in the past
- ☐ No, I do not have a disability and have not had one in the past
- ☐ I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.
For example:
Job Title: Date of Hire: