Employee Accommodation Verification Form

It is the policy of Auburn University, at all levels, to employ, to advance in employment and to treat qualified employees and applicants with disabilities without discrimination. Where an employee is determined to have an ADA-qualifying disability, reasonable workplace accommodations will be made.

(This section to be completed by Employee)

I, _____, authorize my physician
(Employee name – please print)
_____or any of the employees or agents
(Physician's name)
of_____to provide medical
(Name of practice)
information and answer questions regarding my condition to the University, in order to determine my eligibility for services.

Employee's Signature _____Date_____ Banner ID# _____

THE FOLLOWING SECTION MUST BE COMPLETED BY THE TREATING PHYSICIAN.

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.

Important Note to Treating Physician: *The above- named employee is requesting reasonable workplace accommodations for a disability. We appreciate your cooperation in providing the following information, at the employee's request. This information will be maintained in a separate location from the employee's personnel file in the ADA office, and its contents shared only on a need-to-know basis. Complete only those sections you feel are applicable to this patient's request for workplace accommodations*.

Name of Physician/Certified Med. Practitioner
(Print):_____ Specialty_____

Address_____City_____ST_____Zip_____

Phone (____) _____FAX (____) _____E-mail_____

Date of last appointment: _____ Next Appointment: _____

Diagnosis: _____

Recurring or Episodic Symptoms:

Pg. 2 Disability documentation for Employee/Patient Name: _____

(Please attach additional pages if necessary.)

Anticipated duration of condition: _____

Frequency of symptoms: _____

Severity of condition/symptoms: _____

Substantial limitations of major life activities associated with the condition:

Please refer to the attached job description to answer the following questions. (If the employee's job description is not attached and one is needed for reference, please contact the ADA Office for Employees at 334-8444-4794 or by fax at 334-844-4793.)

Are there essential job functions that will be limited by the condition? ◯ **Yes** ◯ **No**
If yes, please list the job functions here:

Are there any essential functions of the job that cannot be performed at all, with or without an accommodation? ◯ **Yes** ◯ **No**
If yes, please list the job functions here:

Suggestions/Comments regarding non-temporary workplace accommodations by Physician:

With my signature, I certify that the above information is true and documented as part of the patient's medical record.

_____ _____

Signature – Physician or Certified Medical Practitioner **Date**

Please return this form by email (eeo@auburn.edu), fax (334.844.4793) or mail to: Affirmative Action/ Equal Employment Opportunity Office, 317 James E. Foy Hall, Auburn University, Alabama 36849. Call (334) 844-4794 if you have any questions.