Employee Accommodation Verification Form

It is the policy of Valdosta State 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 ADAAA-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 of
(Physician's Name– Please print)

_____to provide medical information and answer
(Name of Practice)

questions regarding my condition to the University, in order to determine my eligibility for services.

Employee's Signature _____Date_____Employee 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, 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: _____

(Feel free to attach additional pages, if necessary.)

Anticipated duration of condition: _____

Frequency of symptoms: _____

Severity of condition/symptoms: _____

Substantial limitations associated with the medical 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 Office of Human Resources at 229-333-5709 or by fax at 229-259-5030)

Are there any essential functions of the job that cannot be performed at all, with or without accommodations? _____

If yes, please list the job functions here: _____

_____

Are there job functions that will be limited by the medical condition? _____

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 information by FAX (229) 259-5030 or mail to: Valdosta State University Office of Human Resources 1500 N. Patterson Street, Valdosta, GA 31698. Call (229) 333-6435 if you have any questions. Thank you.

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