Iowa State University

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 (DAR).
- Complete Section 1 below and have the physician or care provider complete Section 2 and submit the **Documentation of Disability** form to ***University Human Resources, 1218 Madden Building, 2221 Wanda Daley Drive, Ames, IA 50011***, via facsimile at ***515-294-1702***, or via email to ***UHRDAR@iastate.edu***. Questions may be directed to ***515-294-3753***.
- Provide a copy of the employee's job description to the physician or care provider. The employee's supervisor or University Human Resources Employee & Labor Relations Office can assist the employee.

The DAR and Documentation of Disability forms are necessary to initiate a request for accommodation - available online at: https://www.hr.iastate.edu/tools-for-employees/workplace-accommodations. If, after receiving all of the documentation, ISU concludes the employee is eligible, the Leave and Accommodations Coordinator will make a final decision on behalf of the university.
The DAR process covers accommodations made for an employee's health condition, including pregnancy.

Section 1: To be completed by employee:

_____ _____

Employee name Job Title

_____ _____

Department/College/Division 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 health care provider.
Human Resources maintains the confidentiality of medical information obtained through the reasonable accommodation process and such records will not be released except as required by law.

_____ _____

Employee signature Date

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 any 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. Consistent with the Genetic Information Nondiscrimination Act, family medical history, genetic information, or genetic services history should not be provided.

To complete this form (see attached, Page 2, Section 2), you should 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 them 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. For weight restrictions, please include whether the restriction applies to lifting, carrying, pushing, and pulling.
   _____
   _____
   _____
   _____
   - 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. Please include a duration for the suggested accommodations.
   - _____
     _____ 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)

_____

Provider Phone Number

_____

Provider Fax Number