University of Vermont
Office of Accessibility Services

Employee Disability Documentation Form

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

A qualified professional not related to the employee may complete this form to support the employee's request for accommodations intended to facilitate equal access to employment opportunities at UVM. This information will be used in conjunction with the employee's self-report to determine reasonable accommodations on an individual basis.

While this documentation may be sufficient in establishing the presence of a disability, recommendations on this form do not automatically bind OAS to determine eligibility for specific accommodations. A provider's recommendations are taken into consideration as part of a full review that includes a multitude of factors.

Name:_____ Today's Date:_____

Date of Diagnosis:_____ Date of Last Contact:_____

Diagnosis:_____

Anticipated duration of the condition: ☐ 6 months ☐ 1 year ☐ more than 1 year

Major Life Activity Limitations

Check the corresponding box to indicate the severity of limitation for each major life activity that impacts the employee due to the diagnosis indicated above. The limitation of major life activity should be compared to the general population and should not take into account mitigating measures (e.g. medications or treatments that reduce the impact of the condition).

Major Life Activity	No Limitation	Mild Limitation	Moderate Limitation	Substantial Limitation
Caring for oneself	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Bodily functions	☐	☐	☐	☐
Talking	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Breathing	☐	☐	☐	☐

Major Life Activity	No Limitation	Mild Limitation	Moderate Limitation	Substantial Limitation
Lifting	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Interacting with others	☐	☐	☐	☐
Listening	☐	☐	☐	☐
Speaking	☐	☐	☐	☐
Seeing	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Reaching/Grasping	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Performing manual tasks	☐	☐	☐	☐

List any side effects of current medication or treatment and the impacts they may have on the person:

Have you and the person discussed the impacts of their condition at work? ☐ Yes ☐ No

Do you have recommendations for reasonable accommodations to assist the person in performing the essential functions of their job?

How else might the person's disability limit their major life activities?

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The information I have provided is accurate to the best of my knowledge, and the condition for which I treat the employee is within the scope of my professional licensure or certification.

Name and credentials of provider: _____

License number and state: _____

Associated organization: _____

Address: _____

Phone number: _____

Signature: _____ Date: _____

Submit this completed form to the Office of Accessibility Services (OAS):

Email: access@uvm.edu
Fax: 802-656-0739
Mail: Office of Accessibility Services
University of Vermont
633 Main Street
A-170 Living/Learning
Burlington, VT 05405

Questions? Call the Office of Accessibility Services: 802-656-7753