

**Office of Institutional Access and Equity  
Southern Methodist University**

**Employee Documentation of Disability Form**

**Employee Section**

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**Employee Instructions:** Please complete the Employee Section of this form and submit it to your physician. Please inform your physician of the essential functions of your position and your request for a reasonable accommodation by submitting a copy of the Employee Reasonable Accommodation Request Form and/or Job Evaluation Form to your physician. After your physician completes the Employee Documentation of Disability Form, please submit it and the Employee Reasonable Accommodation Request Form to the ADA/504 Coordinator in the Office of Institutional Access and Equity to initiate a request for a reasonable accommodation. These confidential forms will not be placed in your personnel file and will be maintained in the Office of Institutional Access and Equity.

**Authorization and Release of Information:**

I, \_\_\_\_\_, hereby authorize my physician to release to and discuss with the Office of Institutional Access and Equity any and all information related to my impairment that

What is the duration of the impairment? \_\_\_\_\_

Please describe how the impairment substantially limits a major life activity (e.g., walking, breathing, hearing, speaking, seeing, learning, eating, sleeping, thinking, performing manual tasks, lifting, major bodily functions):

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Please describe any medications and/or corrective measures that have been prescribed or recommended and their effect:

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Please describe how the impairment impacts the essential functions of the employee's position:

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Please identify any accommodations that could assist the employee in performing the essential functions:

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Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ License Number: \_\_\_\_\_ State: \_\_\_\_\_

Type of Practice: \_\_\_\_\_ Email: \_\_\_\_\_ Phone:ld as Tc 4:

Physician's Name: \_\_\_0c001 \_\_\_d\_\_\_\_\_mld as Tc 4: