Arkansas State University
Office of Affirmative Action
Phone 870-972-2015/Fax 870-972-3337

PROFESSIONAL DOCUMENTATION OF DISABILITY

***This form is confidential and is to be completed by a physician or licensed professional. The purpose of this form is to assist ASU Office of Affirmative Action in providing accommodations to support the employee.

Will your evaluation report concerning this employee be included with this form?
Yes ☐ No ☐

Date: _____

Employee Name: _____

Employee Address: _____

_____

Diagnosis and Description of the Disabling Condition: _____

_____

Date of the last examination: _____

Please list specific recommendations: _____

_____

Current functional limitations that may inhibit this employee in the work environment: _____

_____

_____

Do you consider this illness/disorder to be a disability? Yes ☐ No ☐

Do you consider this disability to be permanent? Yes ☐ No ☐

Print name and title of examining physician or professional: _____

_____

Address and phone number of examining physician or professional: _____

_____

_____ _____
Signature of Examining Physician or Professional Date Signed
Note: Signature must be the signature of physician or professional