SIU Southern Illinois University
CARBONDALE

DISABILITY SUPPORT SERVICES
STUDENT HEALTH CENTER 220
MAIL CODE 4705
374 EAST GRAND AVENUE
CARBONDALE, ILLINOIS 62901

618/453-5738
618/615-4492 VP
618/453-5700 FAX

disabilityservices.siu.edu

Health Care Provider Verification

*(To be completed by Health Care Provider only)***

This information is being requested in order to determine if an employee is a person with a disability as defined by the Americans with Disabilities Act of 1990 and the ADA Amendments Act of 2008, and whether they may be eligible to receive accommodations under the ADA.

This information will be kept private and used only by the ADA Coordinator's Office. To discuss this form or other means of providing verification, please contact the ADA Coordinator at Lcare@siu.edu or 618-453-5738.

**Please do not provide any genetic information of any kind about this employee or their family members on this form. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other covered entities from requesting genetic information of employees or their family members.

Employee Name: _____

Determination of Disability

An employee has a disability and may be eligible for workplace reasonable accommodations if he or she has an impairment that substantially limits one or more major life activities.
The following questions are to assist in determining whether an employee has a disability.

Does the employee have a physical or mental impairment? ☐ YES ☐ NO

If yes, what is the impairment/diagnosis? _____
_____
_____

Is the impairment permanent, or of indefinite duration? ☐ YES ☐ NO

If not permanent or indefinite, what is the anticipated duration of the impairment? _____
_____
_____

Does the impairment substantially limit one or more major life activities? ☐ YES ☐ NO

If yes, explain: *(Note: The impairment does not need to significantly or severely restrict the person's activities to meet the standard of being substantially limiting.)*

_____
_____
_____
_____
_____

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Recommendations for Accommodations (if known):

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Additional Comments:

_____
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_____

Medical Provider Signature: _____

Medical Provider Printed Name: _____

Date: _____

Name of Medical Practice: _____

Address: _____

City, State, Zip: _____ _____ _____

Phone: _____

Delivery instructions for Health Care Provider: Please send the completed form to the ADA Coordinator at Disability Support Services, SHC 220 MC 4705, 374 E. Grand Ave Carbondale, IL 62901.
You may provide completed form to employee to deliver. You may contact us for a secure upload link.