**The Office of Disability Services (ODS) at Wright State University coordinates reasonable accommodations for employees with diagnosed and qualifying disabilities in accordance with the Americans with Disabilities Act, as amended. In doing so, ODS staff enter an interactive process in order to implement the most appropriate accommodation strategies for the workplace. As part of the interactive process, ODS seeks input from the employee's licensed medical provider. The licensed medical provider completing this form should be licensed in the field of expertise to make the diagnosis.**

**The Office of Disability Services will keep this information confidential and it will not be added to an individual's personnel file. The collected data will only be used in accordance with federal regulations as outlined in Title 41, Code of Federal Regulations Part 60-741.23(d). Please feel free to contact the Office of Disability Services with any questions or concerns you might have regarding the information you are being asked to provide.**

 **PART ONE: RELEASE OF INFORMATION AUTHORIZATION (TO BE COMPLETED BY THE EMPLOYEE)

For the purpose of establishing eligibility for accommodations and services, the Office of Disability Services will ask for documentation of your medical condition. Please sign below, indicating you have given the licensed medical provider below permission to release specific medical information that directly relates to the functional impact of your disability, to the Office of Disability Services at Wright State University.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Employee Name (Printed)** |  | **Signature** |  | **Date** |

 **PART TWO: EMPLOYEE AND MEDICAL CONDITION INFORMATION (TO BE COMPLETED BY LICENSED MEDICAL PROVIDER)**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Employee's Name |  | Date of Last Contact with Employee |

Please describe the employee's medical condition that is related to the request for an ADA accommodation. Approximately when was the medical condition diagnosed and how long is the medical condition expected to last?

|  |
| --- |
|  |

Please describe how this medical condition may affect this employee at work, specifically how may this condition affect the employee's ability to perform the essential functions of their job. (You may ask for a job description to make this assessment.)

|  |
| --- |
|  |

Please list any alternative accommodations that you feel are reasonable and would assist this employee in performing their essential job duties. Describe any specific concerns you may have or other ways that we may further assist this employee.

|  |
| --- |
|  |

LICENSED MEDICAL PROVIDER INFORMATION (TO BE COMPLETED BY LICENSED MEDICAL PROVIDER)

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name and Title (Printed) |  | Signature  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Professional License Number  |  | Date |

Medical Provider Office Address and Phone Number

**Please mail or fax this form using the contact information below. For privacy purposes, please do not email this form.**Wright State University
Office of Disability Services
3640 Colonel Glenn Highway
180 University Hall
Dayton, OH 45435-0001
Fax: (937) 775-5699