Medical Verification - Physician's Statement Form

Procedures:

The Ball State University employee identified on this form is requesting an accommodation due to his/her physical or mental disability. In order to consider the accommodation request University policy requires that current medical verification of the physical or mental disability be provided by the employee's attending physician. In order to be considered current, the Physician's Statement must be within **six (6) months prior** to the date of the accommodation request unless the disability is a learning disability or ADHD, then the medical verification documentation must be within **three (3) years prior** to the date of the request.

Please complete this form, mark it confidential, and forward to:

Assistant Director, Institutional Equity and Affirmative Action
Employee Relations and Affirmative Action
2000 W. University Avenue, AD 002
Muncie, IN 47306
FAX: (765) 285-5615

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic Information of employees or their family members. In order to comply with this law, **we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA**, includes an individual's family medical history, the results of an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee's Name:_____

Home Address: _____

Physician's Name:_____

Physician's Phone #_____ Physician's FAX # _____

Dates of Treatment:_____

Probable Duration of Condition: _____

Is Employee substantially limited in any major life activities as a result of his/her health condition? If so, please identify the major life activities.

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_____
_____
_____
_____
_____

Is Employee unable to perform any of the essential functions of his/her job or limited in her/her ability to do so? Please list any existing restrictions (details) and whether temporary or permanent. If temporary, please indicate duration of restrictions.

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_____

Based upon your knowledge of Employee's condition, are there any accommodations that Ball State can provide that you believe would permit Employee to perform the essential functions of his/her job?

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Does Employee require leave from work or a reduced schedule as a result of his/her health condition? If so, please indicate what additional leave is required and/or what schedule of work Employee is able to adhere to and what you estimate to be the expected duration of this need.

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_____

Will the condition cause episodic flare ups periodically preventing Employee from performing his/her job functions and if so, please provide the anticipated frequency and duration of such flare ups as well as any accommodations that the employee will require as a result.

_____
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_____

Please provide any additional information that you believe would assist Ball State in determining, in consultation with Employee, whether an accommodation can be provided to permit him/her to perform his/her job. We stress that you should not provide information that should not be discussed under GINA.

_____
_____
_____
_____
_____
_____

Dated: _____ Physician's Signature: _____

Type of Practice: _____

Business Name: _____

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FAX: (765) 285-5615
Department Phone: (765) 285-1843