University of Pittsburgh

Request for Documentation to Certify Disability
(To be Completed by a Diagnosing Physician or Health/Mental Health Care Provider)

Disability Resources and Services
Office of Institutional Engagement and Wellbeing

31st, Floor Cathedral of Learning
4200 Fifth Avenue
Pittsburgh, PA 15260
Phone: 412-648-7890
Fax: 412-624-3346
drsrecep@pitt.edu
www.drs.pitt.edu

Employee Name:

The above is an employee of the University of Pittsburgh. The employee has requested a workplace accommodation due to a medical condition. The employee believes that an accommodation is necessary to enable him/her to perform the essential functions of their job. Please answer the following questions, as completely as possible. We require your complete medical opinion, so please feel free to include a more detailed narrative response to any of the questions if needed to more fully respond. The information you provide will be confidential.

When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies.

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 an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we ask that you not provide any genetic information in your responses to this request for medical information.

1. Does this employee have a physical or mental impairment?
   Yes ☐ No ☐

   If yes, please state the type of impairment:

2. Is this person currently under your care for treatment of this impairment?
   Yes ☐ No ☐

3. Does this employee's impairment substantially limit any major life activities?

   Yes ☐ No ☐

   If yes, which major life activities are limited:

4. What is the duration or expected duration of the employee's impairment?

5. In what specific way(s) and to what extent does the impairment affect the employee's ability to perform the functions of their job?

6. Please describe any accommodations that would allow this employee to be able to perform their essential job functions:

7. If leave is the accommodation, please identify the duration of the leave AND to the return to work date:

8. Would performing any of the job functions listed result in a direct safety or health threat to this employee or other people (co-workers, members of the general public, etc.?)

   Yes ☐ No ☐

If yes, please describe which job function (s) would pose such a threat:

the direct safety or health threat posed:

any reasonable accommodation that would eliminate the direct safety or health threat, or reduce it to an acceptable level:

Provider Signature: Date (dd-mm-yyyy):

Name and Title:

License Number:

Address:

Phone Number:

Thank you for taking the time to provide this information on behalf of your patient. We will use the information you have provided to evaluate the employee's request for reasonable accommodation and will follow up should we have additional questions.