Office of Equal Employment Opportunity/Affirmative Action & Diversity
Department of Disability Services 601 S. Martin Luther King Jr. Drive
115-F Blair Hall
Winston-Salem, NC 27110-0003

336-750-8658 Phone **336-750-2035** Fax DDS@wssu.edu Email

Faculty/Staff Disability Verification Form Request
To be completed by **Requesting Employee**

Winston-Salem State University is committed to compliance with the Americans with Disabilities Act (1990) the American with Disabilities Amendments Act (2008), and Section 504 of the Rehabilitation Act (1973). The purpose of this form is to assist Winston-Salem State University in determining whether, or to what extent, a reasonable accommodation will allow an employee to safely and effectively perform the essential functions of his or her job.

Name:____DOB: ____________________

Diagnosed Disability:____

Brief Job Description: ____

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By my signature, I hereby authorize my health care provider,

Provider Name: ____

Provider Address: ____

Provider Phone: (xxx-xxx-xxxx): ______________________________

*Provider Fax (xxx-xxx-xxxx):*_________________________________

to furnish information concerning my specified disability to the Department of Disability Services. I further agree that the Disability Services Coordinator may contact my health care provider named above to obtain additional information, if needed related to my limitations and recommended accommodations.

Printed Name:______________________________________Date: ______________

Signature:____

~ Please return this form to the Department of Disability Services ~