Disability Verification Form
(For faculty/staff/residents/postdocs)

TO BE COMPLETED BY THE INDIVIDUAL'S HEALTHCARE PROVIDER

The purpose of this form is to establish that this individual has a physical or mental impairment that limits one or more major life activities and the impact on essential job functions. This form is designed to help us make that determination. Complete documentation guidelines are available at: https://oie.sites.jhu.edu/documentation-guidelines-for-individuals-with-disabilities/

Today's Date: _____ Status (Check): Faculty ☐ Staff ☐ Trainee ☐
Individual's Name: _____ JHU School: _____

DIAGNOSIS

1) Please state the complete diagnosis:

_____
_____

2) How did you arrive at your diagnosis? Please check all relevant items below:

Structured or Unstructured interviews	☐	Medical tests	☐
Interviews with other persons	☐	Medical History	☐
Behavioral Observations	☐	Developmental History	☐

3) Please briefly describe as appropriate the history of presenting symptoms and past functioning, duration of the disorder, relevant development, historical and familial data.

_____
_____
_____

HISTORY AND PROGNOSIS

	Month	Date	Year		Other
Date condition was first diagnosed				[redacted]	
Date individual first seen for the condition					
Date most recently seen for this condition					
Expected duration of condition				Permanent	
How long do you anticipate the impact	3 months	6 months	1 year	More than one year	
Anticipated return to work date				TBD at a later date	
The condition is	stable	improving	worsening	cyclically variable	
The prognosis is	poor	fair	good	excellent	
How often is this individual seen	weekly	monthly	3-6 months	yearly	

4) Is the individual currently taking medication(s) for this issue? YES ☐ NO ☐

If yes, what medications is the individual currently taking? For each medication, describe the side effects and any impact on performance. Do limitations/symptoms persist even with medications?

Medication and Dosage	Side Effects	Academic/Work Impact	Persistence of Symptoms

5) Which specific symptoms currently manifesting themselves might affect the individual's ability to do essential functions?

_____
_____
_____

6) Is the individual restricted from performing any of the activities listed below?

Maximum Minutes per Per hour	**0 minutes Fully Restricted**	**15 minutes**	**30 minutes**	**45 minutes**	**60 minutes Not Restricted**
Standing					
Walking					
Sitting					
Squatting/kneeling					
Bending (at waist)					
Twisting (at waist)					
Use of hands/wrists. R, L, or Both (Circle Affected area)					
Keyboarding/ Repetitive hand motions					
Use of arms/Shoulders R, L, or Both (Circle Affected area)					
Use of Legs R, L, or Both (Circle Affected area)					
Overhead lifting/ Reaching					
Climbing/Using Ladders					

6b) May not lift or carry objects more than _____LBS.
May not push/pull (force required) more than_____LBS.

7) Does the impairment substantially limit the operation of a major bodily function? NO ☐ YES ☐

If yes, please describe what bodily functions are affected.

_____
_____
_____

8) Please list any specific accommodations or services to address the functional limitations identified above

_____
_____
_____
_____
_____
_____
_____

9) Have there been any changes in the individual's condition in the past 12 months?
NO ☐ YES ☐ Please explain.

_____
_____
_____
_____

10) Do you anticipate any changes in the individual's condition/medication in the next 12 months?
NO ☐ YES ☐ Please explain.

_____
_____
_____
_____

11) Is the individual working with another physician or specialist to treat the condition(s)?
NO ☐ YES ☐ Please explain.

_____
_____
_____
_____

12) Is there anything else you think we should know about the individual's medical condition?

_____
_____
_____
_____

Note: The diagnosing professional must have expertise in the differential diagnosis of the documented disorder or condition, follow established best-practices in the field, and not be related to the patient.

PLEASE TYPE OR PRINT CLEARLY

Name/Title _____
Signature_____ Date: _____
License/Certification #_____ State _____
Address _____
City, State, Zip Code_____
Phone _____ Fax _____

Please return form with a letter describing in full detail more information about the medical issue to JHU as quickly as possible.

For Employees: Please return this form and the letter to: Disability Services, Office of Institutional Equity, Johns Hopkins University, Wyman Park Building, Suite 515, 3400 N. Charles Street, Baltimore, MD 21218. Phone: (410) 516-8075 Fax: (410) 367-2665 Email: oiedisability@jhu.edu