Ohio | Department of Administrative Services

Disability Verification Form for the Encouraging Diversity, Growth, and Equity Program

In addition to completing your application for certification into Encouraging Diversity, Growth, and Equity (EDGE) program on Ohio Business Gateway, the following form is required for each proprietor; for each limited partner who owns any interest, for each general partner, or for each stockholder owning any of the voting stock who is applying due to a mental or physical disability to finish processing your application. Please note that the below form is not necessarily exhaustive; **you may be asked to submit additional documentation if the State Equal Employment Opportunity Coordinator believes it is necessary**.

You may submit all applicable documentation either by email at das-eod.bccu@das.ohio.gov, by fax at 614-728-5628 (Attn: Todd McGonigle), or by mail at:

Ohio Department of Administrative Services
Equal Opportunity Division
Business Certification and Compliance Unit
c/o Todd McGonigle
4200 Surface Rd.
Columbus, OH 43228

Failure to submit required documentation may be cause to deny your application.

If you have any questions, please contact the Equal Opportunity Division of the Ohio Department of Administrative Services at 614-466-8380.

I. This section to be completed by applicant:

Name:

Address:

City: State: ZIP:

Phone number: Date of birth:

II. This section to be completed by licensed medical professional:

Does the individual listed in Section I of this document have a disabling condition as defined by the Americans with Disabilities Act of 1990, as described below?

"The term 'disability' means, with respect to an individual,
- a. a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- b. a record of such an impairment; or
- c. being regarded as having such an impairment."

Mark one:	☐ Yes	☐ No
If yes, mark one:	☐ Physical	☐ Mental
Is this disability permanent?:	☐ Yes	☐ No

If no, please explain:

Briefly describe the relevant facts supporting this individual's disability designation:

I certify as a medical professional that the information contained in this form is true to the best of my knowledge.

Name: Title:

Address: City, State, ZIP:

Agency: License Number:

_____ _____

Signature Date