Date Received

HEALTH CARE PROVIDER CERTIFICATION FORM

_____ _____

Employee's Name Last 4 digits of Social Security No.

The above-referenced individual has identified you as the health care provider who is treating the medical condition for which he/she is seeking reasonable accommodation. Attached is the employee's signed medical release. Please complete this certification form **and** the essential functions guide and return it in the envelope provided. Please write **legibly**; if clarification is needed, you will be contacted by a personnel representative. Thank you again for your assistance.

Date of your last examination of this individual: _____

To discuss this matter, I am requesting that a department representative contact me by phone at:

_____

A. Major Life Activities

1. Does this person have a medical condition, that makes one or more of his/her major life activity/activities[1] difficult to perform?

   ☐ Yes ☐ No

2. If yes, the major life activity/activities affected is/are: _____

B. Duration of Medical Condition

1. Is this medical condition temporary? Yes ___ No ___

2. If yes, please state the expected duration of this condition: _____

[1] Major life activities include, but are not limited to, walking, talking, breathing, seeing, hearing, lifting, caring for oneself, learning, thinking, concentrating, interacting with others, speaking, performing manual tasks, reading, sitting, and working.

C. Medical Restrictions

1. Please list the medical restriction(s) that make the major life activity/activities difficult to perform. Please be as **specific** as possible by listing duration and extent of the restriction (e.g., cannot lift over 50 pounds; unable to stand for more than 1 hour; unable to walk for more than 1 block; unable to work more than 6 hours/day; unable to perform multiple projects simultaneously):

_____
_____
_____

D. Reasonable Accommodation Request

1. Please specify what type of accommodation you would recommend for this patient:

☐ Purchase of Assistive Device(s): _____
☐ Removal of Communications Barrier: _____
☐ Purchase of Assistive Services: _____
☐ Removal of Architectural Barrier: _____
☐ Job Restructuring: _____
☐ Modified Work Schedule: _____
☐ Reassignment to Another Position: _____
☐ Other: _____

2. Does the employee's medical condition necessitate this proposed accommodation?

☐ Yes ☐ No

Explain: _____
_____
_____

3. Does this proposed accommodation enable this patient to perform the essential functions of his/her position?

☐ Yes ☐ No

Explain: _____
_____

ESSENTIAL FUNCTIONS GUIDE

For each essential function listed, please check if this person can perform that function, with or without accommodation, or not at all.
If you indicate that an accommodation is needed, please specify the accommodation.

Name of Employee: _____

Class _____ Title _____ Department _____

Work Shift, if applicable: _____

General Description of Position:

Essential Function	Able to Perform without an accommodation.	Able to Perform with an accommodation. (Identify Below)	Unable to Perform with or without an accommodation.
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

As to each essential function for which the individual seeks an accommodation, please identify your recommended accommodation:

I, the undersigned health care provider, certify that the information I have provided regarding the above-referenced individual is complete and accurate to the best of my knowledge. I understand that my cooperation is necessary for the employer to make an accurate determination regarding my patient's reasonable accommodation request.

_____	_____
Health Care Provider's Signature	*Date*
_____	_____
Print Name	*License No.*
_____	_____
Phone Number	*Area of Practice*