EMPLOYEE ADA HEALTH CARE PROVIDER'S MEDICAL CERTIFICATION FORM

INSTRUCTIONS TO THE HEALTH CARE PROVIDER

A request for a reasonable accommodation has been made by our employee, who has also provided a signed authorization for the release of relevant medical information on the next page:

Employee Name	*Job Title*

We are asking for your assistance with the ADA interactive process to determine what reasonable accommodation(s), if any, may be needed to enable the employee to perform the essential functions of his/her job here at [COMPANY NAME]. A copy of the pertinent job description and job analysis are attached so that you may refer to the essential functions and other requirements of the job.

We are requesting you to provide feedback to the following questions based on your medical expertise. Please respond fully to the questions on this form to help determine whether the employee has a qualifying disability, and what limitations the employee may have concerning his/her ability to perform the essential functions of the job. When you have completed and signed the form, please return it as soon as possible to the address below.

This request for reasonable accommodation is being made in accordance with the Americans with Disabilities Act, Title I, and the [COMPANY NAME]'s ADA Accommodation Policy. This form should be completed by the Health Care Provider most knowledgeable about the patient's impairment and the effects of the impairment.

BACKGROUND ON ADA DISABILITY:

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities, or has a record of such impairment. "Substantially limits" under the ADA has been broadened to allow someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or expected duration less than or equal to six months.

The Americans with Disabilities Act (ADA) provides examples of "major life activities," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA) NOTICE:

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 are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.' (29 C.F.R. 1635.8(b)(1)(i)(B)).

If you have questions about this request, please contact:

[NAME]
[COMPANY NAME]
[STREET] • [SUITE] • [CITY, STATE, ZIP]
[PHONE] Office • [PHONE] Cell • [E-MAIL]

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NOTE: the information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA, and with respect to the job that the employee holds with this organization.

To be completed by EMPLOYEE						
	Employee Name		**D.O.B.**		**Employee ID**	
	Job Title:		**Department:**			
	I authorize my medical provider(s) _____ **to release the following information from my patient file to the [COMPANY NAME] for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).**					
	Employee Signature:				**Date:**	

To Be Completed by the HEALTH CARE PROVIDER						
	INSTRUCTIONS: Attached are copies of the employee's job description and a job analysis which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. **Please review both the attached job description and job analysis and then complete and sign this form.**					
	Physician/Health Care Provider Name:		**Specialization / Type of Practice:**			
	Address:		**Email:**		**Phone:**	

Questions to help determine whether an employee has a qualifying disability. A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activities.

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

2. What is the impairment?

3. Is the impairment permanent? Yes No

4. If <u>not</u> permanent, how long will the impairment likely last?

5. Is this a condition which:

- **A.** requires periodic visits for treatment by a health care provider? Yes No
- **B.** continues over an extended period of time? Yes No
- **C.** may cause episodic rather than a continuing period of incapacity? Yes No

6. Is the patient taking medications or treatments that would be expected to affect job performance, that would pose a direct threat or safety risk? Yes No
(See attached job description for statement of duties)

If yes, please explain

7. Does the impairment affect a major life activity? Yes No

Employee ADA Health Care Provider's Medical Certification Form

I certify that the employee has a physical, mental, emotional, impairment that limits one or more major life activity. Below, please indicate the life function affected and the limitations of the employee.

Physical Activity	Mild Limitation	Moderate Limitation	Severe Limitation
Sitting			
Standing			
Walking			
Bending Over			
Climbing			
Reaching Overhead			
Kneeling			
Pushing & Pulling			
Crouching/stooping			
Lifting or Carrying			
• 10 lbs or less			
• 11 to 25 lbs			
• 26 to 50 lbs			
• 51 to 75 lbs			
• 76 to 100 lbs			
• Over 100 lbs			
Repetitive Use of Hands			
• Right Only			
• Left Only			
• Both			
Simple/Light Grasping			
• Right Only			
• Left Only			
• Both			
Firm/Strong Grasping			
• Right Only			

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• Left Only			
• Both			
Fine motor, right hand			
Fine motor, left hand			

Indicate Level of Mental, Emotional, and Sensory Limitations

Pace of Work	Fast Avg Below Avg	Reasoning	Mild Moderate Severe
Manage Multiple Priorities	Mild Moderate Severe	Hearing	Mild Moderate Severe
Intense Customer Interaction	Mild Moderate Severe	Reading	Mild Moderate Severe
Multiple Stimuli	Mild Moderate Severe	Analyzing	Mild Moderate Severe
Frequent Change	Mild Moderate Severe	Verbal Communication	Mild Moderate Severe
Short-term Memory	Mild Moderate Severe	Written Communication	Mild Moderate Severe
Long-term Memory	Mild Moderate Severe	Vision	Mild Moderate Severe
Attention Span	Mild Moderate Severe		

ADDITIONAL COMMENTS REGARDING LIMITATIONS PERTAINING TO ATTACHED JOB DESCRIPTION

Refer to Essential Functions Attachment when Answering these Questions

To Be Completed by the **HEALTH CARE PROVIDER**

Questions to help determine whether an accommodation is needed.

1. What limitation(s) in major life activities is/are interfering with this employee's job performance?

2. What essential job function(s) listed in the job analysis is the employee having trouble performing because of the limitation(s)?

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3. How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the essential job functions listed in the attached job analysis?

Questions to help determine effective accommodation options.

1. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

2. How would your suggestion(s) improve the employee's performance?

Comments.

SIGNATURE of HEALTHCARE PROVIDER: *Stamps and Designee Signatures **NOT** Accepted*	**Date:**

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S CONFIDENTIAL MEDICAL FILE.

PLEASE SCAN AND RETURN COMPLETED FORM VIA EMAIL TO:

[NAME]
[COMPANY NAME]
[STREET] • [SUITE] • [CITY, STATE, ZIP]
[PHONE] Office • [PHONE] Cell • [E-MAIL] [COMPANY NAME]