Print Form

Medical Certification of an ADA Qualifying Impairment

Employees requesting a reasonable accommodation pursuant to the Americans with Disabilities Act are asked to have an appropriate health care professional complete the following form certifying that the employee is eligible to receive an accommodation.

Employee name: _____

Nature and severity of the employee's impairment:_____
_____

Anticipated duration: _____
_____

Permanent of long term impact:_____
_____

Major life activities substantially limited by the impairment: (*e.g. walking, speaking, breathing, performing manual tasks, seeing, hearing learning, caring for oneself, sitting, standing, lifting or reading-activities that an average person can perform with little or no difficulty*)
_____
_____
_____

Work related restrictions that necessitate a reasonable accommodation for this employee:
_____
_____
_____

Name of attending physician or practitioner (please print)_____
Address: _____
_____
_____
Phone: _____

_____
Signature of attending physician or practitioner

The information recorded on this form is confidential and should not be disclosed without proper authorization.