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 or 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 Date

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