**Medical Certification of an ADA Qualifying Impairment**

Employees requesting a reasonable accommodation pursuant to the Americans with Disabilities Act of 1990 are asked to have an appropriate health care professional complete the following form certifying that the employee is eligible to receive an accommodation. (Please make information legible for reading).

**SECTION I: TO BE COMPLETED BY THE EMPLOYEE**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Employee Name |  | Date |
|  |  |  |
| Position |  | Work Location |

**SECTION II: TO BE COMPLETED BY THE PHYSICIAN**

|  |
| --- |
| Nature and severity of the employee’s impairment: |
|  |
| Anticipated Duration: |
|  |
| 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): |
|  |
| Functional and physical work related restrictions that necessitate a reasonable accommodation for this employee: |
|  |
| Accommodations necessary for this employee to be able to perform the essential functions of his/her position: |
|  |

**SECTION III: PHYSICIAN CERTIFICATION**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name of attending physician or practitioner (please print) |  | Telephone Number |
|  |  |  |
| Address |  | Fax Number |
|  |  |  |
| Signature of attending physician or practitioner |  | Date |