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IN CONFIDENCE

EMPLOYEE ADA MEDICAL CERTIFICATION

NOTE: the information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA

Employee Name		D.O.B.		Employee ID	
Job Title:		Department:			

I authorize my medical provider(s) _____ to release the following information
from my _____

EMPLOYEE ADA MEDICAL CERTIFICATION

To Be Completed by the
HEALTHCARE 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)?
- 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 _____ HEALTHCARE PROVIDER ' \$ 7 ()
Stamps and Designee Signatures NOT Accepted