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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 2) HEALTHCARE PROVIDER *'$7(*
Stamps and Designee Signatures NOT *Accepted*