**HENRICO COUNTY PUBLIC SCHOOLS**
Attn: Human Resources Office
3820 Nine Mile Road, Henrico, VA 23223-0420
P.O. Box 23120
Phone: 804.652.3664, Fax: 804.652.3763

# ADA Employee Accommodation Medical Certification

## SECTION I: For Completion by the EMPLOYEE

Your Name: _____
First MI Last

Your Job Title: _____ Work Location: _____

Your Regular Work Schedule: _____

***Please attach a copy of your official Henrico County Public Schools job description to this document prior to completion by your healthcare provider.***

## SECTION II: For Completion by the HEALTHCARE PROVIDER

**Instructions to HEALTHCARE PROVIDER**

A request for a reasonable accommodation has been made by our employee, _____ _____ . In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer the questions on this form to help determine disability and reasonable accommodation.

**BACKGROUND**

An employee has a disability if he/she has an impairment that substantially limits one or more major life activities or a record of such impairment. "Substantially limits" under the ADA Amendments Act (ADAAA) has been broadened to allow someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or expected duration less than or equal to six months.

The ADAAA provides examples of "major life activities," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

• **PLEASE WRITE LEGIBLY** • **DO NOT LEAVE ANY LINES BLANK** •

Today's Date: _____

Healthcare Provider's Name (please print): _____

Type of Practice/Medical Specialty: _____

Business Address: _____

Phone: _____ Fax: _____

**SECTION II (cont.): For Completion by the HEALTHCARE PROVIDER**

**Please answer these questions to help determine disability and reasonable accommodation:**

1. Please review the attached job description. (If no job description is attached, please discuss the position with our employee to determine essential job duties.)

   Is the employee able to perform the essential job functions of this position with or without reasonable accommodation? Yes ○ No ○

   - If *yes,* please continue to question #2.

   If *no*, how long will the employee be unable to perform these job duties?

   ____ # of weeks ____# of months ____ permanently

2. Does the employee have a physical or mental impairment? Yes ○ No ○
   - If *yes*, what is the impairment?

   _____

3. What limitations are interfering with job performance, and how do they affect the employee's ability to perform the job functions? _____

   _____

4. What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position? _____

   _____

5. The employee's typical schedule is _____. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position? _____

   _____

6. How would your suggestions improve the employee's job performance? _____

   _____

7. How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated? _____

   Any additional comments or suggestions: _____

   _____

_____ _____

Physician Name (Please Print) Date

_____

Signature of physician completing form