Employment of Individuals under the Americans with Disabilities Act
Certification of Physician or Practitioner

This form is for employees to notify ACC of a disability. The physician should complete it. The employee must follow the guidelines in the Guideline/Procedure for AR#6.01.003.

The ADA prohibits employment discrimination against "qualified individuals with disabilities." A qualified individual with a disability is an individual with a disability who is qualified for (meets the skill, experience, education, and other job-related requirements) a position held or desired and who, with or without reasonable accommodation, can perform the essential functions of a job.

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we ask that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

This form may be filled out, printed, or typed by the employee's physician.

Employee's Name_____ Employee's eID: _____

1. Does the employee have a physical or mental impairment: ☐ Yes ☐ No

2. If the employee has a physical or mental impairment, does it significantly limit a major life activity such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, or major bodily function: ☐ Yes ☐ No

3. If the response to question 2 is "Yes," identify the major life activity, activities, or major bodily function and explain how they are substantially limited.

_____

_____

_____

_____

_____

4. Estimated Duration of Condition(s):

☐ Less than 6 months ☐ More than 6 months ☐ Lifetime
☐ Unknown/Undetermined
☐ Pregnancy- The patient is pregnant and has an expected delivery date of (MM/DD/YY): _____.

5. When did you start treating this patient for the condition for which they are seeking an Accommodation? _____.

6. Work restrictions or limitations (list the number of hours in the workday):

EMPLOYEE MAY PERFORM ACTIVITY:	NONE	OCCASIONALLY	FREQUENTLY	CONSTANTLY	NOT APPLICABLE
Lifting maximum _____lbs.					
Reaching above shoulder R/L					
Keyboarding/computer use					
Repetitive hand/wrist motion R/L					
Sitting					
Standing/Walking					
Climbing stairs/ladders					
Teaching					
Working					
Speaking					
Work in-person/onsite					
Attend/participate in meetings					
Interact with others (this includes					

students, co-workers and/or customers)					
Other (please describe):					
Other (please describe):					

7. Describe any recommended accommodations. Be as specific as possible (e.g. a piece of office equipment or device, etc.)

_____
_____
_____
_____
_____
_____

8. If you recommend a leave of absence as an accommodation for the patient, check the recommended leave and complete the accompanying questions.

- Continuous Leave (leave for a single block of time)
    - What is the time period for which you request continuous leave?

      Leave Start date: _____

      Leave end date: _____
- Reduced Work Schedule (a leave schedule that reduces the usual number of working hours per week or hours per workday)
    - What is the reduced work schedule you recommend (*e.g., 4 hours per day, 3 days per week*)? _____
    - What is the time period for which you recommend a reduced work schedule?

      Reduced work schedule start date: _____

      Reduced work schedule end date: _____

Intermittent Leave (leave taken in separate blocks of time)

- If applicable, what is the estimated frequency and duration of intermittent leave (*e.g., 4 hours duration at a frequency of 2 times per month*)?

  Duration: _____ (mark one) ☐ hour(s) OR ☐ day(s)

  Frequency: _____ time(s) per (mark one) ☐ week OR ☐ month

  Start date: _____ End date: _____

9. Continuous Leave (leave for a single block of time)

   - What is the time period for which you request continuous leave?

     Leave Start date: _____

     Leave end date: _____

   Reduced Work Schedule (a leave schedule that reduces the usual number of working hours per week or hours per workday)

   - What is your recommended reduced work schedule (*e.g., 4 hours per day, 3 days per week*)? _____

   - What is the time period for which you recommend a reduced work schedule?

     Reduced work schedule start date: _____
     Reduced work schedule end date: _____

   - Intermittent Leave (leave taken in separate blocks of time)
     - If applicable, what is the estimated frequency and duration of intermittent leave (*e.g., 4 hours duration at a frequency of 2 times per month*)?

       Duration: _____ (mark one) ☐ hour(s) OR ☐ day(s)

       Frequency: _____ time(s) per (mark one) ☐ week OR ☐ month

       Start date: _____ End date: _____

10. Please provide any other information that might help ACC evaluate this request.

_____
_____
_____
_____
_____
_____

Name of Licensed Physician or Practitioner: _____

Address: _____

Phone: _____ License #_____

Signature _____ Date: _____