

Medical Certification of an ADA Qualifying Impairment



Employees requesting a reasonable accommodation pursuant to the Americans with Disabilities Act are asked to have an appropriate health care professional complete the following form certifying that the employee is eligible to receive an accommodation.

Employee name: _____

Nature and severity of the employee's impairment: _____

Permanent or long term impact: _____

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 than an average person can perform with little or no difficulty)* _____

Work related restrictions that necessitate a reasonable accommodation for this employee:

Name of attending physician or practitioner (please print) _____

Address: _____

Phone: _____

Signature of attending physician or practitioner

The information recorded on this form is confidential and should not be disclosed without proper authorization.