Americans with Disabilities Act(ADA)
Medical Certification for Accommodation

The information provided on this form must pertain only to the condition for which the employee is requesting accommodation under the Americans with Disabilities Act (ADA).

To be completed by Employee

Name: _____ Phone #: _____

Position/Title:_____ J #:_____

By submitting this form to your health care provider, you authorize your provider to release the completed form, which may contain protected health information (PHI) as defined by HIPAA and similar state and federal laws, to the administrators of the American's with Disabilities Act at Jackson State University. You may rescind authorization at any time; however, failure to provide information necessary to evaluate your leave request, will impact its approval.

Employee Signature: _____ Date: _____

To be completed by the Health Care Provider

Instructions to the Health Care Provider: Attached are copies of the employee's job description and a job analysis which indicates the essential functions of the position and includes the physical/mental demands and the environmental conditions associated with the job. **Please review both the attached job description and job analysis prior to completing this form.**

Health Care Provider Name: _____

Type of Practice/Speciality: _____

Address: _____

Phone Number: _____ Fax Number: _____

Questions to help determine whether an employee has a qualifying disability.

Patients Medical Dx:_____

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

2. If yes, please describe the mental or physical impairment.

_____

_____

_____

_____

_____

3. Is the impairment permanent? ☐ Yes ☐ No

4. If not permanent, what is the expected duration of the impairment? _____

5. Is this a condition which:

a. Requires periodic visits for treatment by a health care provider? ☐ Yes ☐ No

b. Continues over an extended period of time? ☐ Yes ☐ No

c. May cause episodic rather than a continuing period of incapacity? ☐ Yes ☐ No

6. Does the impairment affect a major life activity? ☐ Yes ☐ No

7. If yes, what major life activities is/are affected?

☐ Caring for Self ☐ Walking ☐ Hearing ☐ Lifting ☐ Interacting with Others

☐ Standing ☐ Seeing ☐ Sleeping ☐ Reaching ☐ Concentrating

☐ Manual Tasks ☐ Speaking ☐ Thinking ☐ Learning ☐ Breathing

☐ Working ☐ Toileting ☐ Sitting ☐ Reproduction

☐ Other (describe): _____

8. Does the impairment **substantially** limit the major life activity? ☐ Yes ☐ No

9. If yes, which one(s)?

_____

_____

Questions to help determine whether an accommodation is needed.

10. What limitation(s), if any, is interfering or may interfere with the essential function(s) of the employee's job?

_____

_____

_____

11. What essential function(s) of the job, if any, is the employee having difficulty performing or may have difficulty performing because of the limitation(s)?

_____

_____

_____

_____

_____

12. How does the employee's limitation(s), if any, interfere with his/her ability to perform the essential function(s) of the job, if they do?

_____

_____

_____

_____

Questions to help determine effective accommodation options.

13. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

14. How would your suggestion(s) improve the employee's performance?

Additional Comments:

Signature of Health Care Provider

Date

Return completed form to:
Jackson State University, Division of Human Resources
P.O. Box 17208, Jackson, MS 39217

Phone (601) 979-2015 | Fax: (601) 979-5856
E-mail: hrservices@jsums.edu