E A S T   O R A N G E   S C H O O L   D I S T R I C T

DIVISION OF LABOR RELATIONS & EMPLOYMENT SERVICES

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ADA: Accommodation Medical Certification Form

Dear Physician:

A request for an employment-based reasonable accommodation has been made by our employee____ (name). To assist us with this process, please complete the following questions below.

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 the 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 the next question.

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?

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

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

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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 their position.

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Provider's name and business address: ____

Type of practice / Medical specialty: ____

Telephone: (________)______________________________ Fax: (________)__________________________

Signature of Healthcare Provider ____
Please provide your official stamp (if available)

Date: ______________________________