



UNIVERSITY OF
SOUTH DAKOTA

Request for Disability Accommodation in Employment: Health Care Provider Certification

To the Employee: Please complete the employee and Health Care Provider contact information.

Employee Name: _____

Address: _____

Phone Number _____

Health Care Provider: _____

Address: _____

Phone Number: _____

Fax Number: _____

To the Health Care Provider: Attached is a copy of the employee's job description which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. Please review the attached, then complete and sign this form.

Section A: Questions to help determine whether an employee has a qualifying disability. A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activity.

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

2. What is the impairment? _____

3. Is the impairment long-term or permanent? Yes No

4. If not permanent, how long will the impairment likely last? _____

5. Does the impairment mean that the employee is
substantially limited in one or more major life functions? Yes No

6. If yes, what major life activity/activities is/are affected:

- | | | |
|--|--|--|
| <input type="checkbox"/> caring for self | <input type="checkbox"/> thinking | <input type="checkbox"/> standing |
| <input type="checkbox"/> interacting with others | <input type="checkbox"/> concentrating | <input type="checkbox"/> lifting |
| <input type="checkbox"/> breathing | <input type="checkbox"/> learning | <input type="checkbox"/> reaching |
| <input type="checkbox"/> hearing | <input type="checkbox"/> speaking | <input type="checkbox"/> performing manual tasks |
| <input type="checkbox"/> seeing | <input type="checkbox"/> sitting | <input type="checkbox"/> working |
| <input type="checkbox"/> walking | <input type="checkbox"/> other _____ | |

Section B: Questions to help determine whether an accommodation is needed.

1. What limitation(s) in major life activities is/are interfering with this employee's job performance? _____

2. What of the essential job function(s) listed in the essential job description is the employee having trouble performing because of the limitations? _____

3. How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the essential job function(s) listed in the attached job description? _____

Section C: Questions to help determine effective accommodation options.

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

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

Comments: _____

If additional information is required we will contact you. Thank you for your attention.

All information relating to an accommodation request, including medical documentation, shall be maintained in a file separate from employment files and shall be treated as confidential medical records with access limited to the staff of Disability Services, supervisors who need access to the information regarding necessary work restrictions and accommodations, first aid personnel (when appropriate), and review by government officials investigating compliance with ADA, FMLA, or other pertinent law. Please contact The University of South Dakota representative listed below if you have any questions. Consent for release of information accompanies this request. Attach additional pages if necessary.

Certification:

Medical Practitioner / Physician Name: _____

Specialization: _____

Signature:

(Original signature only)

Date form completed: _____

Please return this form (in the return envelope) to:

Name of The U. Representative: _____

Signature:

(Original signature only)

Title: _____

Date of request: _____