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:

- [ ] caring for self
- [ ] thinking
- [ ] standing
- [ ] interacting with others
- [ ] concentrating
- [ ] lifting
- [ ] breathing
- [ ] learning
- [ ] reaching
- [ ] hearing
- [ ] speaking
- [ ] performing manual tasks
- [ ] seeing
- [ ] sitting
- [ ] working
- [ ] walking
- [ ] 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?

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________________________________________________________________________

________________________________________________________________________

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

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________________________________________________________________________

________________________________________________________________________

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?

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________________________________________________________________________

**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?

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________________________________________________________________________

________________________________________________________________________

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

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________________________________________________________________________
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 by fax or mail to:

Name of the University of South Dakota Representative: ________________________________

Signature (Original signature only): __________________________________________________________________________

Title: ________________________________________________________________________________________________

Date of request: ________________