



## Medical Certification for ADA Reasonable Accommodation

### **Instructions**

This form is designed to identify the medical condition/symptoms and restrictions/limitations prohibiting an LCC employee from performing certain essential functions of his/her position. ***A job description, including ADA checklist, must be attached to this form prior to the form's completion.***

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Employee Name \_\_\_\_\_  
(Last) (First) (Middle)

Employee Banner ID \_\_\_\_\_ Job Title \_\_\_\_\_

Department \_\_\_\_\_ Supervisor Name \_\_\_\_\_

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After review of the attached job description, please indicate employee's job-related restrictions (check all that apply)

Lifting no more than \_\_\_\_\_ pounds

Hours restrictions (work no more than \_\_\_\_\_ hours per day or \_\_\_\_\_ hours per week)

No use of  left  right  arm  leg (if use is restricted, list specific restrictions)

Use of special/modified equipment/devices (explain)

Other (Please be very specific):

Please state the diagnosis(es) and provide a description of the employee's medical condition/symptoms that support the restrictions listed above:

***I have reviewed appropriate job description prior to completing this medical certification. I certify that the above information is an accurate and complete representation of the patient's work restrictions and reasons for said restrictions.***

Medical Professional's Printed Name \_\_\_\_\_

Medical Professional's Signature \_\_\_\_\_ Date \_\_\_\_\_

Medical Professional's Degree & License \_\_\_\_\_  
(i.e. DO, MD, PhD, licensed psychologist, etc.)

Medical Professional's Business Phone \_\_\_\_\_

Medical Professional's Business Name & Address \_\_\_\_\_  
\_\_\_\_\_