

# **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.***

Employee Name: type name here Employee Banner ID: Type Banner ID here

Job Title: type job title here Department: type department name here.

Supervisor Name: type supervisor name here

**This section is to be completed by the Healthcare Provider**

**Instructions to Healthcare Provider:**

A request for a reasonable accommodation has been made by our employee indicated above. In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise.

**Background:**

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities, or has a record of such an impairment. “Substantially limits” under the ADA has been broadened to allow someone with an impairment to be “regarded as” having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or expected duration less than or equal to six months.

The Americans with Disabilities Act (ADA) provides examples of “major life activities,” including “caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

Provider Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Practice/Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Completion by the Health Care Provider:**

1. Does the employee have a physical or mental impairment? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Please describe the employee’s medical condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. When did the medical condition begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long is it expected to last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the medical condition or accompanying treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please review the attached job description (if no job description is attached, please discuss the position with the employee to determine essential job duties and typical schedule). Is the employee able to perform the essential functions of this position in a typical schedule with, or without, reasonable accommodation?

Yes, with reasonable accommodation \_\_\_\_\_

Yes, without reasonable accommodation \_\_\_\_\_

No, they are unable to perform the essential job functions with or without accommodation \_\_\_\_\_

If “No”, how long will the employee remain unable to perform these job functions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If “Yes”, what adjustments to the work environment or position responsibilities would enable the employee to perform job functions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If “Yes”, how long will the employee need the reasonable accommodation to perform these job functions? \_\_

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1. Additional comments or suggestions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When form is complete, please either:**

**Mail to Lansing Community College Human Resources, 610 N Capitol Ave, Lansing, MI 48901**

**or fax to 517-483-1883.**