Date _____

Dear Physician or Health Care Practitioner

RE: **ADA: Accommodation Medical Certification Review**

Our employee_____ (employee's name) has made a request for a Reasonable Accommodation. In order to assist with reviewing their request, we are requesting you to provide feedback to the following questions based on your medical expertise.

Please answer these questions to help determine disability and reasonable accommodation. Review the attached job description. (If there is no job description attached, please discuss the position with the employee to determine primary/essential job duties).

1) Is the employee able to perform the primary/essential job functions of this position without a reasonable accommodation?

   Yes ☐ **No** ☐ **(check one)**

   If *yes,* please continue to next question.

   If *no*, how long will the employee need a reasonable accommodation?

   _____ # of weeks _____ # of months _____ unable to provide a date*

   *If unable to provide a date, when will the employee be medically reevaluated?

   _____

2) Does the employee have a physical or mental impairment?

   Yes ☐ **No** ☐ **(check one)**

   If *yes,* what is the impairment?

3) What limitation(s) is/are interfering with job performance, and how does it interfere with the employee's ability to perform the specific primary/essential job function(s)?

4) What adjustments to the work environment, equipment or position responsibilities would enable the employee to perform the primary/essential job functions of that position?

5) The employee's typical work schedule is _____ .
Please list any adjustments that need to be made to the employee's work schedule to enable the employee to perform the primary/essential functions of that position?

6) How would your suggestions improve the employee's job performance?

Any additional comments or suggestions:

_____
Please Print Physician/Health Care Practitioner's Name

_____ _____
Signature of Physician/Health Care Practitioner Date

Health Care Practitioner's Contact Address and Telephone Number:

_____
_____
_____
_____

Thank you for completing this information. Please email this form directly to:

Office of Human Resources
Coppin State University
2500 W. North Avenue
Baltimore, MD 21216
410-951-3666
410-951-2669 (Fax)

Note ***:***

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. ***"Substantially limits" under the ADAAA 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 ADAAA 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."*