Human Resources

IN CONFIDENCE

Georgia Institute of Technology

# EMPLOYEE ADA MEDICAL CERTIFICATION

**NOTE: The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA**

To be completed by the **EMPLOYEE**

| | | | | | |
|---|---|---|---|---|---|
| **Employee Name** | | **D.O.B.** | | **Employee ID** | |
| **Job Title:** | | **Department:** | | | |

**I authorize my medical provider(s) _____ to release the following information from my patient file to the Georgia Institute of Technology for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).**

| | |
|---|---|
| **Employee Signature:** | **Date:** |

To Be Completed by the **HEALTHCARE PROVIDER**

**INSTRUCTIONS:** Attached are copies of the employee's job description and a job analysis which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. **Please review both the attached job description and job analysis and then complete and sign this form.**

| | | | | | |
|---|---|---|---|---|---|
| **Physician Name:** | | **Specialization / Type of Practice:** | | | |
| **Address:** | | **Fax No:** | | **Phone No.:** | |

**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 activities.

1. Does the employee have a physical or mental impairment? Yes ☐ No ☐
2. What is the impairment?_____
3. Is the impairment permanent? Yes ☐ No ☐
4. If not permanent, how long will the impairment likely last? ***(Response Required)*** _____
5. Is this a condition which:
   - **A.** requires periodic visits for treatment by a health care provider? Yes ☐ No ☐
   - **B.** continues over an extended period of time? Yes ☐ No ☐
   - **C.** may cause episodic rather than a continuing period of incapacity? Yes ☐ No ☐
6. Is the patient taking medications or treatments that would be expected to affect job performance, that would pose a direct threat or safety risk? Yes ☐ No ☐
   (See attached job description for statement of duties)
   If yes, please explain: _____
7. Does the impairment affect a major life activity? Yes ☐ No ☐

☐ I certify that the employee has a physical, mental, emotional, impairment that limits one or more major life activity. Below, please indicate the life function affected and the limitations of the employee.

| Physical Activity | Mild Limitation | Moderate Limitation | Severe Limitation |
|---|---|---|---|
| Sitting | | | |
| Standing | | | |
| Walking | | | |
| Bending Over | | | |
| Climbing | | | |

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| | | | | |
|---|---|---|---|---|
| | Reaching Overhead | | | |
| | Kneeling | | | |
| | Pushing & Pulling | | | |
| | Crouching/stooping | | | |
| | Lifting or Carrying | | | |
| | • 10 lbs or less | | | |
| | • 11 to 25 lbs | | | |
| | • 26 to 50 lbs | | | |
| | • 51 to 75 lbs | | | |
| | • 76 to 100 lbs | | | |
| | • Over 100 lbs | | | |
| | Repetitive Use of Hands | | | |
| | • Right Only | | | |
| | • Left Only | | | |
| | • Both | | | |
| | Simple/Light Grasping | | | |
| | • Right Only | | | |
| | • Left Only | | | |
| | • Both | | | |
| | Firm/Strong Grasping | | | |
| | • Right Only | | | |
| | • Left Only | | | |
| | • Both | | | |
| | Fine motor, right hand | | | |
| | Fine motor, left hand | | | |

## Indicate Level of Mental, Emotional, and Sensory Limitations

| | | | |
|---|---|---|---|
| Pace of Work | ☐Fast ☐Avg ☐Below Avg | Reasoning | ☐Mild ☐Moderate ☐Severe |
| Manage Multiple Priorities | ☐Mild ☐Moderate ☐Severe | Hearing | ☐Mild ☐Moderate ☐Severe |
| Intense Customer Interaction | ☐Mild ☐Moderate ☐Severe | Reading | ☐Mild ☐Moderate ☐Severe |
| Multiple Stimuli | ☐Mild ☐Moderate ☐Severe | Analyzing | ☐Mild ☐Moderate ☐Severe |
| Frequent Change | ☐Mild ☐Moderate ☐Severe | Verbal Communication | ☐Mild ☐Moderate ☐Severe |
| Short-term Memory | ☐Mild ☐Moderate ☐Severe | Written Communication | ☐Mild ☐Moderate ☐Severe |
| Long-term Memory | ☐Mild ☐Moderate ☐Severe | Vision | ☐Mild ☐Moderate ☐Severe |
| Attention Span | ☐Mild ☐Moderate ☐Severe | | |

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Refer to Essential Functions Attachment when Answering these Questions

To Be Completed by the **HEALTHCARE PROVIDER**

**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 essential job function(s) listed in the job analysis is the employee having trouble performing because of the limitation(s)?

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

**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**

| **SIGNATURE of HEALTHCARE PROVIDER:**<br>*Stamps and Designee Signatures **NOT** Accepted* | **Date:** |
|---|---|

**ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S FILE.**

Rev: 06/15/23

**RETURN FORM TO:**

Georgia Institute of Technology
Human Resources, Employee Relations Services
500 Tech Parkway
Atlanta, GA 30332-0435
Fax: 404-894-4691