INGHAM COUNTY
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 **EMPLOYEE**

Employee Name	**D.O.B.**	**Employee No.**
Job Title:	**Department:**	
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? _____

5. Is this condition considered a chronic 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. Does the impairment affect a major life activity? Yes □ No □

7. If yes, what major life activity(s) is/are affected?

□ Caring for self	□ Walking	□ Hearing	□ Lifting
□ Interacting with others	□ Standing	□ Seeing	□ Sleeping
□ Performing Manual Tasks	□ Reaching	□ Speaking	□ Concentrating
□ Breathing	□ Thinking	□ Learning	□ Working
□ Toileting	□ Sitting	□ Reproduction	□ Other: _____

8. Is the employee substantially limited in one or more of these major life activities? Yes □ No □

9. Is the employee's limitation in any of these major life activities substantial? Yes □ No □

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 ability to perform the essential functions of his/her position?_____

_____

2. What 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 to accommodate the employee in performing the essential functions of the job?_____

_____

_____

2. How would your suggestion(s) address the employee's ability to perform the essential functions of the job? _____

_____

Comments.

_____

_____

_____

_____

_____

SIGNATURE of HEALTHCARE PROVIDER: *Stamps and Designee Signatures **NOT** Accepted*	**Date:**

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

RETURN FORM TO:
ADA Coordinator
Human Resources Department
5303 S. Cedar, Bldg. 2, Suite 2102
Lansing, MI 48911
Tel: 517-676-7336 / Fax: 517-887-4396