ILLINOIS STATE UNIVERSITY
Employee ADA Medical Certification

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

To be completed by **EMPLOYEE**

Employee Name	**D.O.B.**	**Employee ID**
Job Title:	**Department:**	
Employee Signature:		**Date:**

To Be Completed by the **HEALTHCARE PROVIDER**

INSTRUCTIONS: To be completed and signed by the treating health care provider whose practice area must include treatment of the condition for which the employee is requesting reasonable accommodation under the ADA. Please provide thorough answers to all questions **and then return signed form to the Illinois State University Office of Equal Opportunity and Access (OEOA) Direct questions about the Employee's Essential Work Functions to OEOA.**

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

Questions to help determine whether an employee has a qualifying disability.

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 <u>not</u> 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 <u>yes</u>, 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. If yes, please circle substantially limited life activities in #7, above

Responses to Questions 10 -16 should be specific to the Essential Functions of the Employee's Job

To Be Completed by the **HEALTHCARE PROVIDER**

Questions to help determine whether an accommodation is needed.

10. What limitation(s) in major life activities may need accommodation for this employee to perform to the essential functions of his or her job?

_____

_____

11. What, if any, job function(s) is the employee having trouble performing because of the limitation(s)?

_____

_____

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

_____

_____

Questions to help determine effective accommodation options.

13. Do you have suggestions for possible accommodations that would enable performance of the employee's essential job functions? If so, please describe.

_____

_____

14. How would your suggested accommodations enable performance of the employee's essential job functions?

_____

_____

15. If leave is suggested as a possible accommodation, what length of leave is recommended?

_____

16. Would this leave enable the employee to return to work and perform the essential functions of the employee's job?

_____

Comments.

_____

_____

_____

_____

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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 COMPLETED FORM TO:

Carrie Pierson, Deputy ADA Coordinator, Office of Equal Opportunity and Access (OEOA)-Illinois State University
Campus Box 1280, 310 Hovey Hall, Normal, IL 61790-1280
Tel: (309) 438-3383 | Fax: (309) 438-7395