ILLINOIS STATE UNIVERSITY
Employee ADA Medical Certification

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

To be completed by **EMPLOYEE**

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

To Be Completed by the **HEALTHCARE PROVIDER**

INSTRUCTIONS: To be completed and signed by the treating healthcare provider whose practice area must include treatment of the condition for which the employee or job applicant is requesting reasonable accommodation under the ADA. Please provide thorough answers to all questions and then return the signed form to the Illinois State University Office of Equal Opportunity and Access (OEOA). Direct any 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 ◯

Responses to questions 9-15 should be specific to the essential functions of the employee's or applicant's job.

To Be Completed by the **HEALTHCARE PROVIDER**

Questions to help determine whether an accommodation is needed.

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

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

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

Questions to help determine effective accommodation options.

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

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

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

15. Would this leave of absence enable the employee to return to work and perform the essential functions of the employee's job at a later time?

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

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