GEORGIA STATE UNIVERSITY
Employee ADA Medical Certification

The information sought in this form pertains only to the condition for which the Employee is requesting ADA accommodation. All information provided is confidential and will be retained in the Employee's medical file.

To be completed by the **EMPLOYEE**

Employee Name:	**D.O.B.**
Job Title:	**Department:**
Job Description: *See Attached*	
Essential Functions of Employee's Job: *See Attached*	

To Be Completed by the **HEALTHCARE PROVIDER**

INSTRUCTIONS: Please review the attached job description and the essential functions listed above 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.

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 cause substantial limitation of a major life activity? Yes □ No □

7. If yes, please check major life activities affected by the limitation.

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

To Be Completed by the **HEALTHCARE PROVIDER**

Please refer to Essential Functions listed on top of Page 1 when answering these questions:

8. What limitation(s) in major life activities identified on Page 1 need accommodation to enable the employee to perform to the essential functions of his or her job?

_____
_____

9. Based upon the employee's limitations, which of his/her job functions may need a reasonable accommodation?

_____
_____

10. Please explain how the employee's limitation(s) impacts his/her ability to perform the job functions listed in response to Question 9. _____
_____
_____

Questions to help determine effective accommodation options:

11. Do you have any suggestions about possible accommodations to enable the employee to perform the essential functions of his/her job? If so, what are they? _____
_____
_____

12. How would your suggested accommodations enable the employee to perform the essential functions of his/her job? _____
_____
_____

13. Leave (*Important - If leave is suggested as an accommodation, you must provide meaningful answers to all parts of this question based on your current medical opinion. Noting plans to re-evaluate and dates for follow-up appointments will be considered non-responsive.*)

A. If leave is suggested, what amount of leave is recommended? _____

B. Will the suggested leave enable the employee to return upon its conclusion and perform the essential functions of his/her job? ☐Yes ☐No ☐Unknown ☐Other _____
_____

Comments:

_____
_____
_____

Signature of Healthcare Provider (*stamps & designee signatures **NOT** accepted)***:**	**Date:**

RETURN FORM TO:

ADA Coordinator/Benefits Office
Georgia State University
P. O. Box 3982
Atlanta, GA 30302-3982
Tel: 404-413-3330 / Fax: 404-413-3324