ADA Reasonable Accommodation Request
Medical Certification

Details

Patient Name: _____ DOB: _____

Practitioner Name: _____

Practitioner Address: _____ Phone: _____

Current Accommodations:

To the medical practitioner:

Your assistance is appreciated in providing information to determine reasonable accommodation in employment for the above-named employee, who has identified himself/herself as your patient. To assist with the interactive process, we are requesting you provide feedback on the below questionnaire.

The questionnaire will guide accommodation approval and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed response to any questions if needed to answer more fully. Thank you for your assistance.

Please answer the following to help determine reasonable accommodation:

Question #1: Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties.) Is the employee able to perform the essential job functions of this position without an accommodation?

Question #2: Does the employee have a physical or mental impairment?

Question #3: What is the impairment?

Question #4: What limitation(s) is interfering with job performance, and how does it interfere with the employee's ability to perform the job function(s)?

Question #5: What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

Question #6: How would your suggestions improve the employee's job performance?

Question #7: How long will the employee need the reasonable accommodation?

Question #8: When will the patient be medically reevaluated?

Notes:

Additional Notes

Enter Additional Notes.

Certification

Medical Practitioner's Full Name:

Medical Practitioner's Signature

Date form completed: