Skokie School District 73.5
Americans with Disabilities Act (ADA)
Employee Accommodation Medical Certification Form

SECTION I: For Completion by the EMPLOYEE

Your Name:

_____

Your Job Title:

_____

Your Regular Work Schedule:

_____

SECTION II: For Completion by the HEALTH CARE PROVIDER

Instructions to the Physician:
A request for a reasonable accommodation has been made by our employee, identified above. In order to assist with the ADA interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer the questions on this form to help determine the employee's impairment/disability and reasonable accommodation(s) for consideration.

Background: An employee has a disability if he or she has an impairment that substantially limits one or more major life activities, or has a record of such an impairment. The Americans with Disabilities Act (ADA) provides examples of "major life activities," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

Provider Name (please print):

_____

Type of Practice / Medical Specialty:

_____

Business Address:

_____

Phone: _____ **Fax:**_____

1. Does the employee have a physical or mental impairment? _____ Yes _____ No

For Completion by the HEALTH CARE PROVIDER (Cont.)

2. Please describe the employee's medical condition and impairment(s).

_____
_____
_____
_____

3. When did the medical condition begin?

_____

4. How long is it expected to last?

_____

5. Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the medical condition or accompanying treatment. _____
_____
_____

6a. Please review the attached job description. (If none is attached, please discuss the position with the employee to determine essential job duties and typical schedule.) Is the employee able to perform the essential functions of this position in a typical schedule with, or without, reasonable accommodation? _____ Yes, with reasonable accommodation
_____ Yes, without reasonable accommodation
_____ No, they are unable to perform their essential job functions with or without accommodation.

6b. If No, how long will the employee remain unable to perform these job functions?
_____ # of weeks _____ # of months _____ permanently.

6c. If Yes, what adjustments to the work environment or position responsibilities would enable the employee to perform these job functions?

_____
_____

6d. If Yes, how long will the employee need the reasonable accommodation to perform these job functions? _____ # of weeks _____ # of months _____ permanently.

7. Additional Comments or Suggestions:

_____
_____

Healthcare Provider Signature: _____
Date: _____/_____/_____

Please return to: Ms. Samantha Peterson, Assistant Superintendent of Business & Operations/CSBO, speterson@sd735.org. If you have any questions, Ms. Peterson may be reached at 847-324-0509.