

**GEORGIA STATE UNIVERSITY**  
**Employee ADA Medical Certification**

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

To be completed by <b>EMPLOYEE</b>	<b>Employee Name</b>	<b>D.O.B.</b>	<b>Employee ID</b>
	<b>Job Title:</b>	<b>Department:</b>	
	<b>Employee Signature:</b>		<b>Date:</b>

**INSTRUCTIONS:** Attached are copies of the employee's job description and a job analysis which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. **Please review both the attached job description and job analysis and then complete and sign this form.**

<b>Physician Name:</b>	<b>Specialization / Type of Practice:</b>	
<b>Address:</b>	<b>Fax No:</b>	<b>Phone No.:</b>

**Questions to help determine whether an employee has a qualifying disability.** A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activities.

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 affect a major life activity? Yes  No

7. If yes, what major life activity(s) is/are affected?

- |  |                                   |                                       |  |
|--|-----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Caring for self         | <input type="checkbox"/> Walking  | <input type="checkbox"/> Hearing      | <input type="checkbox"/> Lifting       |
| <input type="checkbox"/> Interacting with others | <input type="checkbox"/> Standing | <input type="checkbox"/> Seeing       | <input type="checkbox"/> Sleeping      |
| <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking     | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Breathing               | <input type="checkbox"/> Thinking | <input type="checkbox"/> Learning     | <input type="checkbox"/> Working       |
| <input type="checkbox"/> Toileting               | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Reproduction | <input type="checkbox"/> Other: _____  |

8. Is the employee substantially limited in one or more of these major life activities? Yes  No

9. Is the employee's limitation in any of these major life activities substantial? Yes  No

To Be Completed by the **HEALTHCARE PROVIDER**

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**HEALTHCARE PROVIDER**

**Questions to help determine whether an accommodation is needed.**

- 1. What limitation(s) in major life activities is/are interfering with this employee's job performance?  
\_\_\_\_\_  
\_\_\_\_\_
- 2. What job function(s) listed in the job analysis is the employee having trouble performing because of the limitation(s)? \_\_\_\_\_  
\_\_\_\_\_
- 3. 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.**

- 1. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 2. How would your suggestion(s) improve the employee's performance? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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**

**RETURN FORM TO:**  
ADA Coordinator  
Human Resources Department  
Georgia State University  
University Plaza  
Atlanta, GA 30303  
Tel: 404-413-3314 / Fax: 404-413-3324