SOUTHWEST
TENNESSEE COMMUNITY COLLEGE
OFFICE OF EQUITY & COMPLIANCE

ADA Request for Accommodation Form

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 employee

Employee Name	Social Security#
Job title	Department
Employee Signature	Date

To be completed by the Health Care Provider

INSTRUCTIONS: Attached is a copy of the employee's job description which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. **Please review the attached job description and complete and sign this form**. Also, on your official letterhead, please state the disability findings, showing a correlation drawn from tests to the diagnosis, including the treatment plan. Also include an ultimate prognosis as to the disability and/or condition. **Please attach to this form and forward to: Southwest Tennessee Community College, Human Resources Office, P.O. Box 780, Memphis, TN 38101-0780.**

Physician Name:	Specialization/Type of Practice:
Address:	Phone: Fax:

SECTION I

Questions to 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 long-term or 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 mean that the employee is substantially limited in one or more major life activities? Yes ☐ No ☐

To be completed by the Health Care Provider

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

___ caring for self
___ interacting with others
___ performing manual tasks
___ breathing
___ toileting
___ walking
___ standing
___ reaching
___ thinking
___ sitting
___ hearing
___ seeing
___ speaking
___ learning
___ reproduction
___ lifting
___ sleeping
___ concentrating
___ working
other ___________________

SECTION II

Questions to determine whether an accommodation is needed.

1. What functional limitation(s) in major life activities is/are interfering with this employee's job performance?

2. Have any treatment, medications and/or other remedial measures been prescribed? Yes ☐ No ☐
If yes, please list.

3. Are the above treatment, medications and/or other remedial measures prescribed actually being used? Yes ☐ No ☐

3. What job function(s) listed in the job description is the employee having trouble performing because of the limitation(s)?

4. 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 description?

5. With reference to the attached list of job tasks, please state whether the employee is able to perform each task ***without*** the use of prescribed medication and/or remedial measures.

6. With reference to the attached list of job tasks, please state whether the employee is able to perform each task ***with*** the use of prescribed medication and/or remedial measures.

SECTION III

Questions to 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?

ADA MEDICAL CERTIFICATION

To be completed by the Health Care Provider

SECTION IV

Comments:

____
____
____
____
____

SIGNATURE OF HEALTH CARE PROVIDER:
(Stamps and Designee Signature NOT accepted.)

____ Date ______________________________

All information provided is confidential and will be retained in the employee's medical file.

Please return the requested information to the [Department's Name] by [Date], [Year], so that we may begin reviewing the employee's request. If you have questions or need additional information, please contact [Name and Title] at [Telephone Number] or [Email Address].