District School Board of Pasco County

Office for Employee Relations

Medical Certification of ADA Qualifying Impairment

Individuals requesting a reasonable accommodation pursuant to the Americans with Disabilities Act are required to have a licensed health care provider with expertise about the individual's specific health condition and the limitations imposed by it complete the following form to allow the District to evaluate the request for accommodation and begin the interactive process. Documentation is insufficient if it does not:

- specify the functional limitations due to the disability;
- describe how the limitations impact the essential functions of the employee's position;
- include the anticipated duration of the impairment;
- and/or explain why a reasonable accommodation is needed for the employee to safely perform his/her assigned tasks.

It is the employee's responsibility to provide a job description of their current assignment and information about additional responsibilities that may be impacted by the reported medical condition, not inclusive of any temporary reassignments or setting changes that had been previously approved based on medical documentation that has been previously submitted. All medical information is treated confidentially, not maintained in the employee's main personnel file, and will be used only by authorized individuals with direct need to know and/or evaluate the information for ADA purposes.

FAILURE TO PROVIDE COMPLETE AND SUFFICIENT DOCUMENTATION MAY RESULT IN A DETERMINATION THAT THE EMPLOYEE IS INELIGIBLE FOR REASONABLE ACCOMMODATIONS UNDER ADA.

Forms must be submitted to the Equity Office to initiate the ADA process and consideration of any reasonable accommodations under ADA.

ATTN: Equity Office

Office for Employee Relations

District School Board of Pasco County

7227 Land O'Lakes Blvd.

Land O'Lakes, FL 34638

Phone: (813) 794-2679

Fax: (813)794-2119

SECTION I: TO BE COMPLETED BY EMPLOYEE

Employee #:	**DOB:**
First and Last Name:	Phone:
Position:	**Work Location:**
Supervisor/Administrator:	

RELEASE/VERIFICATION AND ACCURACY

I,____, authorize my health care provider(s) to complete this form for the purpose of exploring coverage and reasonable accommodation under the Americans with Disabilities Act (ADA). In addition, as it relates to this request for ADA accommodation(s) only, I authorize my health care provider to communicate with the Equity Office, both verbally and/or in writing, regarding my disability-related limitations and appropriate reasonable accommodations that may be considered.

I, ____, verify that the information I am submitting in support of my request for an accommodation is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action. I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others in the workplace and/or to me, or if it creates an undue hardship on Pasco County Schools.

Signature:	**Date:**

SECTION II: TO BE COMPLETED BY HEALTHCARE PROVIDER

Name of Healthcare Provider:	
Specialty/Type of Practice:	
Office Phone:	**Office Fax:**
Office Address:	

SECTION II continued: TO BE COMPLETED BY HEALTHCARE PROVIDER

Responses to the following questions may help in determining whether an employee has a disability as defined by the ADA. Please circle YES or NO	
Does the employee have a physical or mental impairment?	**YES NO**
If ***yes,*** what is the impairment(s) and /or diagnosis:	
Is/Are the substantial limitation(s) associated with this diagnosis permanent? If NOT permanent, how long will the limitation(s) likely last?	**YES NO** _____ Weeks _____ Months
NOTE: If the employee requests or requires reasonable accommodations beyond the anticipated duration, an updated Medical Certification will be required.	

Answer the following questions based on what limitations the employee has when his/her condition is in an active state, and what limitations the employee would have if no mitigating measures (e.g., medication, medical equipment, hearing aids, mobility devices, prosthetics, psychotherapy, etc.) were used? Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the **impairment SUBSTANTIALLY limit a major life activity** as compared to most people of the same sex and age in the general population? **YES or NO**

If **YES,** what major life activity is affected? **Check all that apply**

	Bending		Interacting with Others		Reading		Caring for Self
	Breathing		Kneeling		Seeing		Walking
	Carrying		Learning		Sitting		Other:
	Concentrating		Lifting		Speaking		
	Eating		Pushing/Pulling		Standing		
	Hearing		Reaching		Thinking		

And/or what major bodily function(s) is/are affected?

	Bladder		Endocrine		Respiratory
	Bowel		Hemic		Reproductive
	Brain		Immune		Skin
	Cell Growth		Lymphatic		Sensory
	Circulatory		Musculoskeletal		Other:
	Digestion		Neurological		

Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

To help determine whether a reasonable accommodation is needed at work as a direct result of the ADA qualifying impairment, please answer the following:	
In your professional opinion, and after reviewing the job description provided by the employee, **can the individual perform the essential functions of the job without direct threat to their own health and safety and/or the health and safety of others in the workplace**?	**YES NO** **YES, with Accomodations**
In your professional judgment, will the diagnosis/impairment **cause this employee to be unable to report to work in any substantive way?**	**YES NO**
In your professional opinion, and after reviewing the job description provided by the employee, is there a limitation that is interfering with employee's job performance or accessing a benefit of employment? If ***yes,*** **what limitation(s) is interfering with the employee's job performance**? **If *yes,* what job function(s) listed in the job description is the employee having trouble with or unable to perform**?	**YES NO**
To help determine effective accommodation, please answer the following:	
In your professional opinion, what are the recommended suggestions regarding possible accommodations to improve job performance?	
How would your suggestions improve the employee's job performance and allow them to perform the essential functions of their position?	

Licensed Medical Provider Signature	**Date**