District School Board of Pasco County
Medical Certification of ADA Qualifying Impairment

Individuals requesting a workplace accommodation under the **Americans with Disabilities Act (ADA)** must provide medical documentation from a licensed health care provider who has knowledge of the employee's medical condition and the functional limitations associated with it. This information allows the District to evaluate the request and engage in the interactive process to determine whether a reasonable accommodation may be available.

The healthcare provider should focus on identifying the **employee's functional limitations and work-related restrictions**, rather than recommending specific accommodation. The District will review the requested accommodation and determine appropriate accommodation through the ADA interactive process.

Documentation may be considered insufficient if it does not:

- identify the functional limitations related to the medical condition;
- explain how those limitations affect the employee's ability to perform the **essential functions of the position**;
- include the anticipated duration of the limitations; and/or
- provide sufficient information for the District to evaluate the need for a workplace accommodation.

Employees are responsible for obtaining and providing their healthcare provider with a copy of the **current job description** and any relevant information regarding job duties that may be affected by the reported medical condition. Temporary duty assignments or previously approved accommodations should not be used as the basis for evaluating the essential functions of the position.

All medical information will be maintained **confidentially**, will not be placed in the employee's personnel file, and will only be shared with authorized individuals who have a legitimate need to know for purposes of evaluating the accommodation request.

Incomplete or insufficient documentation may delay the District's ability to evaluate the request. The District may request additional information when necessary to complete the ADA interactive process. Completed forms must be submitted to the ADA Coordinator in order to initiate review of the accommodation request.

Please return both sections to the ADA Coordinator:
FAX: 813-794-2119
Email: crc@pasco.k12.fl.us
Phone: 813-794-2679

SECTION I: TO BE COMPLETED BY EMPLOYEE

Employees must complete Section I of this form describing the accommodation they are requesting before submitting the form to their healthcare provider.

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

1. **Essential Functions Acknowledgement** Before submitting this request, please review the essential functions of your position. A copy of the job description may be attached for your reference.

☐ **I have reviewed the essential functions of my position.**

Please list which job duties/functions you believe are affected by your medical condition:

2. **Workplace Limitations** Please describe the specific work-related task(s) or workplace barrier(s) that are difficult for you to perform due to your medical condition:

3. **Specific Accommodation Request Please describe the specific accommodation(s) you are requesting.**

4. **Ability to Perform Job Duties With the accommodation(s) you are requesting, do you believe you will be able to perform the essential functions of your position? ☐ Yes ☐ No ☐ Unsure**
Please briefly explain your response.
Interactive Process Acknowledgment The District will review all accommodation requests through an individualized interactive process. The accommodation requested may not be granted if it is not reasonable or if it would create an undue hardship or safety concern. **☐ I understand that the District will evaluate this request and may discuss alternative accommodations with me.**

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 District, 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 for the District.

Employee Signature Required	**Date**

SECTION II: TO BE COMPLETED BY HEALTHCARE PROVIDER

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

To assist Pasco County Schools in evaluating this accommodation request, please answer the following questions based on your professional knowledge of the patient's medical condition and the functional limitations associated with it. The employee has been instructed to provide you with a **copy of their job description** for review.

For purposes of this form, a **functional limitation** describes how the employee's medical condition affects their ability to perform a work-related activity. Examples may include limits on lifting, walking, standing, sitting, bending, concentrating, communicating, working outdoors, maintaining a schedule, or tolerating certain environmental conditions.

Please describe the employee's functional ability or restriction rather than recommending a specific workplace accommodation or identifying a particular assignment the employee should not perform. For example, rather than stating "no car duty," please describe the underlying limitation, such as the maximum duration of outdoor exposure, environmental conditions that should be avoided, or other medically necessary restrictions.

- Unable to lift more than 20 pounds.
- Unable to stand continuously for more than 30 minutes.

The District will determine whether a reasonable accommodation is available through the ADA interactive process.

> Answer the following questions based on what limitations the employee has when the 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.

Medical Impairment

1. Does the employee have a physical or mental impairment that substantially limits one or more major life activities or major bodily functions?

☐ Yes ☐ No ☐ Unable to determine

If yes, please identify the major life activity or major bodily function affected:

Perform Essential Job Functions

2. Based on the medical condition and the job description provided, in your professional opinion can the employee safely perform the **essential functions of the job**?

☐ Yes ☐ Yes, with functional limitations or restrictions ☐ No

If "Yes, with functional limitations or restrictions" or "No," please complete Questions 4-6 below.

Work Attendance

3. Based on the employee's medical condition, do you anticipate that the employee will be **unable to report to work or maintain a regular work schedule**? ☐ Yes ☐ No

If yes, please explain:

Functional Limitations and Work Restrictions

4. Please identify the employee's specific **functional limitation(s) or medically necessary work restriction(s).** Be specific regarding any applicable weight, distance, duration, frequency, environmental condition, or required recovery period.

Functional Area	No Limitation	Limitation/Restriction – Please Specify
Lifting/Carrying	☐	_____
Standing	☐	_____
Walking	☐	_____
Sitting	☐	_____
Bending/Stooping/Squatting/Kneeling	☐	_____
Pushing/Pulling	☐	_____
Climbing/Stairs	☐	_____
Repetitive activity/use of hands or arms	☐	_____
Outdoor/environmental exposure	☐	_____
Schedule/attendance	☐	_____
Concentration/communication	☐	_____
Other	☐	_____

Impact on Job Duties

5. After reviewing the job description provided by the employee, please identify which **job duties or tasks may be affected** by the employee's medical limitations.

_____
_____
_____

Duration of Limitations

6. Are the limitations:

☐ Temporary Estimated duration: _____

☐ Permanent

☐ Unknown at this time

Provider Name: _____ Provider Signature: _____

License Number: _____ Date: _____

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).

Please return to Pasco County Schools FAX 813-794-2119 Phone 813-794-2300