ADA Medical Certification Form

Employee's Name: Click to type name	Date of Birth: Click to enter DOB

Completed form may be faxed to: (888) 305-0605

Or emailed to: claims@yourbenefitexpert.com

This form must be returned no later than: _____

Failure to return this completed form by the due date may result in the employee being denied a reasonable accommodation.

If you are seeking an accommodation related to pregnancy, childbirth or related conditions, DO NOT fill out this form. Contact your case specialist for the appropriate form.

INSTRUCTIONS FOR HEALTH CARE PROVIDER: Please complete, sign, and date this form so that we may evaluate the above-named employee's request for a leave of absence as a reasonable accommodation under the Americans with Disabilities Act (ADA).

1. **Impairment.** Does the employee have a physical or mental impairment(s), as defined below?

YES ☐ NO ☐

If **yes,** please list impairment(s):_____

_____

_____

If no, please skip to the signature page.

A physical or mental impairment is:

- Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine; or
- Any mental or psychological disorder, such as an intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.
- The disorder or condition should be considered without regard to mitigating measures, such as prostheses, medication, etc. (except ordinary eyeglasses).

A. When did this impairment(s) begin? _____

B. How long is/are impairment(s) expected to last? _____

2. **Limitations on major life activities.** Does the employee's impairment(s) substantially limit one or more major life activities, as described below?

YES ☐ NO ☐

Note: Whether an impairment substantially limits the ability of an individual to perform a major life activity is determined:

- As compared to most people in the general population; and
- Does not need to prevent, or significantly or severely restrict, the individual from performing a major life activity – the impairment only needs to "substantially limit" the employee's ability to perform the major life activity.

If yes, please check all major life activities that are substantially limited by the employee's impairment(s).

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking
☐ Breathing	☐ Interacting With Others	☐ Reading	☐ Standing
☐ Caring For Self	☐ Learning	☐ Seeing	☐ Thinking
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping	☐ Working
			☐ Other (describe)

Major bodily functions:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	☐ Other: (describe)
☐ Circulatory	☐ Immune	☐ Operation of an Organ	

3. **Performance of essential job functions.** Based on the job description and/or your discussions with the employee about his/her essential job duties and work schedule, is the employee able to perform the essential job functions with a typical work schedule, with or without, a leave of absence as a reasonable accommodation?

Yes, without a leave of absence ☐

No, the employee will be unable to perform essential job functions with or without a leave of absence ☐

If you checked either box above, please skip to question number 5.

Yes, with a leave of absence as a reasonable accommodation ☐

4. **Please describe the employee's abilities based on the imposed restrictions and limitations:**_____

Please indicate the frequency of the patient's restrictions: <u>Check all that apply</u>.

Restrictions/ Frequency	Unable to perform	Occasionally (up to 1/3 of the time)	Frequently (1/3 to 2/3 of the time)	Constantly (2/3 or more of the time)
Carrying, Pushing, Lifting 10 lbs.				
Carrying, Pushing, Lifting 20 lbs.				
Carrying, Pushing, Lifting 20-50 lbs.				
Carrying, Pushing, Lifting 50-100 lbs.				
Standing				
Walking				
Sitting				

5. **Reasonable Accommodation**

> **Note:** *A <u>reasonable accommodation</u> may include a modification or adjustment to a job, work environment, or policy/process, such as* modifying a work schedule, providing special equipment, installing workplace accessibility modifications, shifting non-essential duties, or *a leave of absence to allow time for recovery, therapy, training, or other disability-related needs.*

A. **<u>At Work</u>**: What modification or adjustment(s) to the work environment or job would enable the employee to perform his/her essential job functions? _____

a. **Duration:** For how long do you anticipate the employee will need an accommodation(s)
   i. to perform the essential job functions? (Please provide your best medical judgment)

      1. Temporarily: Starting _____ through _____

      2. Permanently: _____

      3. Additional details about duration:_____

b. Next office visit or re-evaluation:_____

B. **<u>Leave:</u>** If the employee needs time off or a leave of absence as an accommodation, how will that time off/leave assist the employee in returning to work (e.g., obtain medical treatment, recover from a flare up, train in use of service animal, etc.)?

_____

_____

C. **Frequency and Duration:** If time off or a leave of absence will assist the employee in returning to work, what are the dates during which you anticipate the employee will need the leave of absence? (**Please provide your best medical judgment as to the appropriate type of leave and the applicable length, frequency, and duration**.)

   a. **Continuous** leave starting on _____through _____

   b. **Reduced schedule** leave starting on_____ through_____with an anticipated work schedule of_____hour(s) per day;_____days per week

   c. **Intermittent leave** starting on_____through_____with an anticipated frequency and duration of absences of:

      i. Frequency: _____ times per _____ week/month (circle one)

      ii. Duration: _____ hours OR _____ day(s) per absence
      (e.g., 2 times per month for up to 4 hours each absence, or 1 absence every 3 months lasting 1 day)

6. **Additional Information:** Are you aware of any other information that should be considered in assessing whether the employee can perform the essential job functions with or without a leave of absence as an accommodation?

_____

Provider Signature: _____

Provider Name (print): _____

Type of Practice/Specialty:_____

Phone Number: (____)_____ Fax Number: _____

Address: _____

_____

Date:_____

IMPORTANT NOTICE REGARDING GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes the manifestation of disease or disorder in family members of the individual, an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services and genetic information of a fetus carried by an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.