



Georgia Institute of Technology
EMPLOYEE ADA MEDICAL CERTIFICATION

IN CONFIDENCE

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		D.O.B.		Employee ID	
	Job Title:		Department:			
	I authorize my medical provider(s) _____ to release the following information from my patient file to the Georgia Institute of Technology for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).					
	Employee Signature:				Date:	

To Be Completed by the HEALTHCARE PROVIDER	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.					
	Physician Name:		Specialization / Type of Practice:			
	Address:		Fax No:		Phone No.:	
	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 <input type="checkbox"/> No <input type="checkbox"/>					
	2. What is the impairment?					
	3. Is the impairment permanent? Yes <input type="checkbox"/> No <input type="checkbox"/>					
	4. If <u>not</u> permanent, how long will the impairment likely last?					
	5. Is this a condition which:					
	A. requires periodic visits for treatment by a health care provider? Yes <input type="checkbox"/> No <input type="checkbox"/>					
B. continues over an extended period of time? Yes <input type="checkbox"/> No <input type="checkbox"/>						
C. may cause episodic rather than a continuing period of incapacity? Yes <input type="checkbox"/> No <input type="checkbox"/>						
6. Is the patient taking medications or treatments that would be expected to affect job performance, that would pose a direct threat or safety risk? Yes <input type="checkbox"/> No <input type="checkbox"/>						
(See attached job description for statement of duties)						
If yes, please explain						
7. Does the impairment affect a major life activity? Yes <input type="checkbox"/> No <input type="checkbox"/>						
<input type="checkbox"/> I certify that the employee has a physical, mental, emotional, impairment that limits one or more major life activity. Below, please indicate the life function affected and the limitations of the employee.						
Physical Activity	Mild Limitation	Moderate Limitation	Severe Limitation			
Sitting						
Standing						
Walking						
Bending Over						
Climbing						



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Reaching Overhead			
Kneeling			
Pushing & Pulling			
Crouching/stooping			
Lifting or Carrying			
• 10 lbs or less			
• 11 to 25 lbs			
• 26 to 50 lbs			
• 51 to 75 lbs			
• 76 to 100 lbs			
• Over 100 lbs			
Repetitive Use of Hands			
• Right Only			
• Left Only			
• Both			
Simple/Light Grasping			
• Right Only			
• Left Only			
• Both			
Firm/Strong Grasping			
• Right Only			
• Left Only			
• Both			
Fine motor, right hand			
Fine motor, left hand			
Indicate Level of Mental, Emotional, and Sensory Limitations			
Pace of Work	<input type="checkbox"/> Fast <input type="checkbox"/> Avg <input type="checkbox"/> Below Avg	Reasoning	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Manage Multiple Priorities	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Hearing	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Intense Customer Interaction	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Reading	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Multiple Stimuli	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Analyzing	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Frequent Change	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Verbal Communication	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Short-term Memory	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Written Communication	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Long-term Memory	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Vision	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Attention Span	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		



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Refer to Essential Functions Attachment when Answering these Questions

To Be Completed by the 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 essential 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 essential 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: <i>Stamps and Designee Signatures NOT Accepted</i>		
Date:		

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S FILE.

RETURN FORM TO:
Georgia Institute of Technology
Human Resources, Employee Relations Services
500 Tech Parkway
Atlanta, GA 30332-0435
Tel: 404-894-3249 / Fax: 404-894-4691