**St. Mary's County Public Schools**
**Americans with Disabilities Act (ADA) Employee Accommodation**
**Medical Certification Form**

**SECTION I: For Completion by the EMPLOYEE**

Your Name: _____
First MI Last SMCPS ID Number

Your Job Title: _____

Your Regular Work Schedule: _____

*** Please attach a copy of your official SMCPS Position Description. You can find your Position Description here:** http://www.smcps.org/hr/schedule-of-classifications-position-descriptions

**SECTION II: For Completion by the HEALTH CARE PROVIDER**

**Instructions to the Health Care Provider:**

A request for a reasonable accommodation has been made by our employee, indicated above. In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer the questions on this form to help determine disability and reasonable accommodation.

**Background**

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities, or has a record of such an impairment. "Substantially limits" under the ADA has been broadened to allow someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or expected duration less than or equal to six months.

The Americans with Disabilities Act (ADA) provides examples of "major life activities," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

Provider Name (please print): _____

Type of Practice / Medical Specialty: _____

Business Address: _____

Phone: _____ Fax: _____

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**SECTION II (cont.): For Completion by the HEALTH CARE PROVIDER**

1. Does the employee have a physical or mental impairment? _____Yes _____No

2. Please describe the employee's medical condition.

_____

_____

3. When did the medical condition begin?

_____

4. How long is it expected to last?

_____

5. Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the medical condition or accompanying treatment.

_____

_____

6a. Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties and typical schedule.) Is the employee able to perform the essential functions of this position in a typical schedule with, or without, reasonable accommodation?

_____Yes, with reasonable accommodation _____Yes, without any accommodation

_____No, they are unable to perform their essential job functions with or without accommodation

The employee is unable to perform the following essential job functions:

_____

_____

6b. If *No,* how long will the employee remain unable to perform these job functions?

_____# of weeks _____# of months _____permanently.

6c. If *Yes,* what specific adjustments to the work environment or position responsibilities would enable the employee to perform each of these job functions?

_____

_____

6d. If *Yes,* how long will the employee need the reasonable accommodation to perform these job functions?

_____# of weeks _____# of months _____permanently.

7. Additional Comments or Suggestions:

_____

_____

**Healthcare Provider Signature: _____ Date: ____/____/____**

When form is complete, please either: Mail to SMCPS, Human Resources, 23160 Moakley Street; Leonardtown, MD 20650; Fax to (301) 475-4201; or Email to slbrown@smcps.org. Please contact: (301) 475-5511, extension 32110 or slbrown@smcps.org