Employee Accommodation Medical Certification Form

Pursuant to the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504), the Shawnee Mission School District will not discriminate against an otherwise qualified individual with a disability in employment. Pursuant to the Genetic Information Nondiscrimination Act (GINA), the District will not discriminate against employees or applicants because of genetic information, or unlawfully request genetic information.

SECTION I: For Completion by the EMPLOYEE

Your Name: _____
First MI LAST

Your Job Title: _____

Your Regular Work Schedule: _____

I authorize my medical provider(s) to complete this form for the purposed of exploring coverage and reasonable accommodations under the Americans with Disabilities Act.

Employee Signature: _____ **Date:** _____

Shawnee Mission School District employees will need to provide their healthcare provider with a copy of their current job description. If you do not have your job description, please contact Human Resources to request a copy.

SECTION II: For Completion by the HEALTH CARE PROVIDER

Instructions to the Physician

A request for a reasonable accommodation has been made by our employee. 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 a physical or mental impairment that substantially limits one or more major life activities; a record (or past history) of such an impairment; or is regarded as having a disability. An impairment does not need to prevent or severely or significantly restrict a major life activity to be considered "substantially limiting." With the exception of ordinary eyeglasses or contact lenses, the ameliorative effect of mitigation measures may not be taken into account when determining whether an impairment is substantially limiting.

The 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: _____

(continued on next page)

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, speaking, 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 reasonable accommodation**

☐ **No, they are unable to perform their essential job functions with or without accommodation**

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

_____# of weeks _____# of months ☐ permanently

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

_____

_____

_____

7. Additional Comments or Suggestions:

_____

_____

Healthcare Provider Signature: _____ Date:_____/_____/_____

* If you have questions, please contact: Jennifer Lumley,SMSD Human Resources at 913.993.6497

Return Completed Form To: _____