GAINESVILLE CITY SCHOOL DISTRICT

HEALTH CARE PROVIDER'S CERTIFICATION OF MEDICAL IMPAIRMENT

Employee (First, Last Name): _____
Home Address (Street, City, State, Zip Code): _____
_____
Home Telephone No.: _____ G #:_____
Position: _____Work Location: _____

An employee who requests an accommodation through the Americans With Disabilities Act (ADA) due to his/her own serious medical condition must present the following completed form to the Department of Human Resources, Benefits Specialist Sherry McElroy. Please review the attached position description and respond to the six questions that follow. Please free to contact Human Resources at 770.536-5275.

Thank you in advance.

Priscilla Collins
Chief Professional Services Department

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1. Identify each diagnosis to indicate whether chronic or acute; permanent or temporary; severity; date of onset; and expected duration.

Diagnosis	Chronic or Acute	Permanent or Temporary	Severity (Mild, Moderate, Severe)	Date of Onset	Expected Duration (Ending Date)

2. Does the employee's medical condition preclude or substantially limit the individual from performing any of the duties listed on the enclosed position description. If so, identify which **specific duties** the employee is precluded from performing or substantially limited in his or her ability to perform **due to medical necessity**. For the purposes of this document, the definition of a substantial limitation means that the employee would not be able to perform the task in a manner that would be comparable to that of the general population.

_____
_____
_____
_____

3. Is there a medical reason to believe that the employee will experience injury, harm or aggravation of his or her medical condition by attempting to perform the duties that you have provided in your response to number 2 above? If so, what is the degree of injury, harm or aggravation that should be expected and what is the likelihood that it will occur? What is the timeframe in which it is likely to occur?

_____
_____
_____
_____

4. Is the employee likely to recover sufficiently to perform the duties described in the attached position description? If so, what is the expected time frame for recovery? If not, what is the **medical reason** that would inhibit recovery?

_____
_____
_____
_____

5. Indicate all major life activities the employee is restricted from or substantially limited in his or her ability to perform. **The ADA has provided some guidance regarding the interpretation of major life activities. These activities include but are not limited to:**

___walking ___speaking ___breathing ___hearing ___seeing
___thinking ___lifting ___learning ___working ___concentrating
___reading ___bending ___eating ___standing ___sleeping
___communicating ___performing manual tasks ___interacting with others
___caring for one's self

6. If it is your professional opinion **based on an objective assessment** that the individual should be restricted from any of the major life activities listed in number 5 above **due to medical necessity**, what types of accommodations or measures do you recommend to enable the employee to perform the duties outlined in the attached position description.

_____
_____
_____
_____

Health Care Provider's Signature: _____

Health Care Provider's Name (Printed): _____

Health Care Provider's Telephone No.: _____

Health Care Provider's Fax No.:_____

Health Care Provider's E-Mail Address:_____

Date Completed by Health Care Provider :_____

You may return this document via fax to 770.287.2019