Richmond Public Schools

MEDICAL CERTIFICATION OF AN A.D.A. QUALIFYING IMPAIRMENT

Dr. Teresa K, Anderson, Director, Employee Relations
ADA Coordinator: Betty F. Stephens
Talent Office and Employee Relations
301 North 9Th Street Richmond, VA 23219
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Employees requesting a reasonable accommodation pursuant to the Americans with Disabilities Act are asked to provide an appropriate health care professional with a copy of their job description, and then have the health care professional complete the following form certifying that the employee is eligible to receive an accommodation. *The information recorded on this form is confidential and should not be disclosed without proper authorization.* ***Please submit through the employee to the attention of: Dr. Teresa K. Anderson, Director of Employee Relations.***

Authorization for Release of Medical Information

(to be completed by employee)

I authorize my physician or Health Care provider to release any information requested by my employer on this form or otherwise release of medical information is requested for process of my Request for an Accommodation for an ADA Impairment.

Employee/Applicant Signature: _____ Date: _____

Employee/Applicant Name: _____ ID #: _____

Home/Cell Phone Number: _____ Birth Date: _____

Employee/Applicant Address: _____

Medical Certification

(to be completed by physician or practitioner)

Nature and severity of the employee/applicant's impairment: _____

_____

Anticipated Duration: _____

Permanent or Long-Term Impact: _____

Major life activities substantially limited by the impairment: (*e.g. walking, speaking, breathing, and performing manual tasks, seeing, hearing learning, caring for oneself, sitting, standing, lifting or reading-activities that an average person can perform with little or no difficult.* ***CHECK ALL THAT APPLIES***

☐ No climbing	☐ No kneeling or squatting	☐ No overhead lifting (greater than __ pounds)
☐ No jumping	☐ Must park close to worksite	☐ No standing/walking (greater than ____hours per day)
☐ No dancing	☐ Must do sedentary/desk work ONLY	☐ No standing/walking (greater than ____minutes without ____minute rest)
☐ No running	☐ No lifting with right/left upper extremity	☐ Other
☐ No bending over	☐ No lifting (greater than _____pounds)	

Work tasks, duties or assignments specified on the job description or described by the employer which medically require reasonable accommodation for this
Employee:_____

Name of attending [physician or practitioner (please print)_____

Address:_____ Phone Number: _____

Physician/Practitioner Signature _____ Date:_____