ADA Reasonable Accommodation Physician's Confirmation

This section to be completed by employee:

Name:____ Employee ID #:_____________________________________

Work Location:__________________________________ Position:____

Name of Patient & Relationship (*if not employee*):____

This section to be completed by physician:

I hereby certify that ____ has been under my care for the treatment of

____.

Physician Note: Please include below a detailed description of the nature of the condition for which you are treating this patient to explain why this condition is disabling and requires a reasonable accommodation under the qualifications of ADA. Please include suggested accommodations. If additional space is needed, please attach it to this form.

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Name of Attending Physician:__________________________ Office of Attending Physician:_________________________

Signature of Attending Physician_______________________________________ Date___________________