PENNRIDGE SCHOOL DISTRICT

Perkasie, Pennsylvania 18944-2295

Human Resources

HEALTHCARE PROVIDER'S CERTIFICATION OF MEDICAL IMPAIRMENT

Employee (First, Last Name): _____

Home Address (Street, City, State, Zip Code): _____

_____

Home Telephone Number: _____

Position: _____ Work Location: _____

Dear Healthcare Provider:

We are responding to your patient's request for an accommodation on the basis of a possible medical impairment. Your assistance in this process would be most beneficial.

Thank you in advance for your assistance.

Tara Mossman

Tara Mossman
Director of Human Resources

1. Have you examined the employee? YES NO (Circle One)

   Date of last examination:_____

2. Does the employee have a "physical or mental impairment?" YES NO (Circle One)

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

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

4. Does the employee's medical condition preclude or substantially limit the individual from performing any of the required duties. 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 and in accordance with guidance promulgated relative to the ADA, 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.**

_____

_____

5. 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 4 above? If so, what is the degree of injury, harm or aggravation that should be expected and what likelihood that will occur? What is the timeframe in which it is likely to occur?

_____

_____

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

_____

_____

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

☐ Walking ☐ Speaking ☐ Breathing ☐ Hearing ☐ Seeing

☐ Thinking ☐ Lifting ☐ Learning ☐ Working ☐ Concentrating

☐ Interacting with Others

8. 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 6 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 job description?

_____

Health Care Provider's Signature	Date
Health Care Provider's Name (please print)	Health Care Provider's Phone Number
Health Care Provider's Fax Number	Health Care Provider's e-Mail