FURMAN UNIVERSITY
ADA MEDICAL CERTIFICATION FORM

Directions:

This medical certification is meant to facilitate documentation of physical or mental disabilities and should be completed by the Furman University employee and his/her Physician. The employee shall complete Part I, then provide the form to the physician to complete Part II, including the contact information and signature section on page 5.

When finished, the physician shall return the completed form to the employee/patient. The employee/patient shall scan the completed form and upload a copy to Box folder that was provided for the purposes of the interactive accommodations process.

Part I: Employee/Patient Information (To be Completed by the Employee)

Employee Name: _____ **Department:** _____

Job Title: _____

I authorize my physician to release medical information to Furman University Office Human Resources for the purpose of determining qualification and reasonable accommodation under the Americans with Disabilities Act.

Employee Signature: _____ **Date:** _____

Part II. Medical Certification: (To be completed by Employee's Physician)

The employee/patient referenced in Part I of this form is seeking a work-related accommodation. State and federal laws require employers to make reasonable accommodations to employees when the accommodation(s) are not unduly burdensome and may be necessary to afford a person with a disability with the equal opportunity to access to the workplace, to perform the essential functions of their job, or to access the benefits and opportunities afforded by the employer.
Please complete Section A, Section B (if applicable), and Section C. When finished, proceed to the Contact Information/Signature section.

Section A – Explanation of Medical Condition

1. Does the employee have a physical or mental impairment? YES _____ NO _____
2. If yes, please describe the physical or mental impairment.

_____

_____

_____

_____

_____

3. Is the impairment permanent? YES _____NO _____
4. If not permanent, how long will the impairment likely last?

_____

_____

5. Is this a condition which:
    a. Requires periodic visits for treatment by a health care provider? YES _____NO _____
    b. Continues over an extended period of time? YES _____NO _____
    c. May cause episodic rather than a continuing period of incapacity? YES _____NO _____

6. Is the patient taking medications or treatments that would be expected to affect job performance that would pose a direct threat or safety risk? YES_____NO_____
If yes, explain:

_____

_____

_____

_____

7. What Activity or Activities does the impairment limit?

8. Additional Comments or Requirements in regard to the impairment:

Proceed to Section B on page 4.

Section B – Identified Limitations (if applicable to medical condition)

Physical Activity	Mild Limitation	Moderate Limitation	Severe Limitation
Sitting			
Standing			
Walking			
Bending Over			
Climbing			
Reaching Overhead			
Kneeling			
Pushing & Pulling			
Crouching/Stooping			
Lifting or Carrying			
• 10 lbs. or less			
• 11 to 25 lbs.			
• 26 to 50 lbs.			
• 51 to 75 lbs.			
• 76 to 100 lbs.			
• Over 100 lbs.			
Repetitive Use of Hands			
• Right Only			
• Left Only			
• Both			
Simple/Light Grasping			
• Right Only			
• Left Only			
• Both			
Firm/Strong Grasping			
• Right Only			
• Left Only			
• Both			
Fine motor, right hand			
Fine motor, left hand			

Indicate Level of Mental Emotional, and Sensory Limitations, if applicable			
Pace of Work	Fast ~ Avg ~ Below Avg	Reasoning	Mild ~ Moderate~ Severe
Manage Multiple Priorities	Mild ~Moderate ~Severe	Hearing	Mild ~Moderate ~Severe
Intense Customer Interaction	Mild ~Moderate ~Severe	Reading	Mild ~Moderate ~Severe
Multiple Stimuli	Mild ~Moderate ~Severe	Analyzing	Mild ~Moderate ~Severe
Frequent Change	Mild ~Moderate ~Severe	Verbal Communication	Mild ~Moderate ~Severe
Short-term Memory	Mild ~Moderate ~Severe	Written Communication	Mild ~Moderate ~Severe
Long-term Memory	Mild ~Moderate ~Severe	Vision	Mild ~Moderate ~Severe
Attention Span	Mild ~Moderate ~Severe		

Section C – Medically Recommended Accommodation(s)

Please refer to Employee's Job Description when answering the questions below:

Would the employee be able to perform the essential job functions listed in his/her job description with or without accommodation? If specific equipment or other accommodation(s) may be needed in order for the employee to perform the essential functions of the job, please list below:

Contact Information/Signature

Physician Name:	
Physician Address:	
Physician Phone Number:	
Physician's Signature:	