UNIVERSITY OF LOUISIANA Lafayette

ADA REASONABLE ACCOMMODATION MEDICAL CERTIFICATION

The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA. All information provided is confidential and will be retained in the employee's medical file in accordance with applicable law.

EMPLOYEE INFORMATION:

To Be Completed by Employee

(Please print)

Name: _____ Date of Birth: ____/____/____
(Last) (First) (MI)

ULID #: _____ Job Title: _____

I do hereby authorize the University of Louisiana at Lafayette to communicate both verbally and in writing, if necessary, with the appropriate health care or rehabilitation professionals with regard to the resolution of my request for ADA accommodation.

_____ ____/____/____
Employee Signature *Date*

HEALTH CARE PROVIDER INFORMATION:

To Be Completed by Employee's Health Care Provider

Review the attached copy of the employee's job description which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. Please complete and sign this form, then return to the EEO/ADA Coordinator at UL Lafayette (see page 4).

Physician Name: _____

Speciality/Type of Practice: _____

Address: _____

Phone #: (_____) _____ Fax #: (_____) _____

QUALIFYING DISABILITY:

The following questions will be used to determine whether the employee has a qualifying disability. For reasonable accommodation under the ADA, an employee has a disability if the person has an impairment that substantially limits one or more major life activity, or a record of such an impairment.

(A substantial limitation is a significant restriction as to the condition, manner, or duration under which the person can perform a particular major life activity.)

1. Does the employee have a physical or mental impairment? ❑ Yes ❑ No

If yes, what is the impairment? _____

_____

2. Is the impairment long-term or permanent? ❑ Yes ❑ No

If ***not*** permanent, how long will the impairment likely last? _____

3. Is this impairment considered a chronic 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

4. Does the impairment mean that the employee is substantially limited in one or more major life activity? ❑ Yes ❑ No

If yes, what major life activity(ies) is/are affected?

❑ Seeing	❑ Walking	❑ Speaking	❑ Caring for oneself
❑ Hearing	❑ Standing	❑ Learning	❑ Performing manual tasks
❑ Eating	❑ Lifting	❑ Reading	❑ Communicating
❑ Breathing	❑ Bending	❑ Concentrating	❑ Working
❑ Toileting	❑ Sitting	❑ Thinking	❑ Other: _____

IS ACCOMMODATION NEEDED? (Use additional sheets as needed)

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions will be used to determine whether an accommodation is needed.

1. What limitation(s) is/are interfering with the employee's job performance?

_____

_____

_____

_____

2. What job function(s) from the attached job description is/are the employee having trouble performing because of the limitation(s)?

_____

_____

_____

_____

3. Have any treatment, medications, and/or other remedial measures been prescribed? If yes, please list. ❑ Yes ❑ No

_____

_____

_____

_____

4. Are the above treatment, medications, and/or other remedial measures actually being used?
   ❑ Yes ❑ No

_____

_____

_____

_____

5. With reference to the attached job description, please state whether the employee is able to perform each task ***with*** or ***without*** the use of prescribed medication and/or remedial measures.

_____

_____

_____

_____

SUGGESTED ACCOMMODATION(S)? (Use additional sheets as needed)

The following questions will be used to determine effective accommodation options.

1. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

_____

_____

_____

_____

2. How would your suggestion(s) improve the employee's job performance?

_____

_____

_____

_____

Additional comments:

_____

_____

_____

_____

_____

_____

SIGNATURE OF HEATLTH CARE PROVIDER:
(Stamps and Designee Signature NOT accepted.)

Signature: _____ Date: _____/_____

For the privacy of our employees, please do not return this form via email.
You may return the completed Medical Certification form to the EEO/ADA Coordinator by:

Fax: (337) 482-1452
Attn: Malika Oubre

Postal Mail: Office of Human Resources
HR Compliance
P.O. Box 40196
Lafayette, LA 70504

Hand delivery: Office of Human Resources
Senior Benefits and ADA Coordinator
111 Boucher Street Buchanan Hall, Room 111

If you have any questions or need additional information, please contact Ms. Malika Oubre, Senior Benefits and ADA Coordinator, at (337) 482-1014 or hrcompliance@louisiana.edu.