ADAA REQUEST FOR ACCOMMODATION
CERTIFICATION FOR HEALTH CARE PROVIDER

Name: _____WFU ID: _____

Department: _____ Supervisor's Name: _____

Please have your medical professional provide the following information. Use additional pages as needed.

For reasonable accommodation under the ADA, a disability exists if the employee has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability.

Does the patient have a physical or mental disability? Yes _____ No _____

If yes, what is the impairment, or the nature of the impairment? (the diagnosis does NOT need to be listed)

_____
_____
_____

Explain how the patient's disability impairs or limits his/her ability to perform assigned job duties (See attached job description)

_____
_____
_____

Is this a permanent or temporary disability? Yes_____ No_____
If this is a temporary condition, please provide the expected duration of the disability.

_____
_____
_____

What specific accommodation(s) do you recommend?

_____
_____
_____

Answer the following question based on what limitations the employee has when the condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population?

Yes _____ No _____

OR Describe the employee's limitations when the impairment is active:

_____

Note: *Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.*

If *yes*, what major life activity(s) (includes major bodily functions) is/are affected?

☐ Bending ☐ Breathing ☐ Caring For Self ☐ Concentrating ☐ Eating	☐ Hearing ☐ Interacting With Others ☐ Learning ☐ Lifting ☐ Performing Manual Tasks	☐ Reaching ☐ Reading ☐ Seeing ☐ Sitting ☐ Sleeping	☐ Speaking ☐ Standing ☐ Thinking ☐ Walking ☐ Working

Major Bodily Functions:

☐ Bladder ☐ Bowel ☐ Brain ☐ Cardiovascular ☐ Circulatory	☐ Digestive ☐ Endocrine ☐ Genitourinary ☐ Hemic ☐ Immune	☐ Lymphatic ☐ Musculoskeletal ☐ Neurological ☐ Normal Cell Growth ☐ Operation of an Organ	☐ Reproductive ☐ Respiratory ☐ Special Sense Organs & Skin ☐ Other: (describe)

Medical Professional's name and business address: _____

_____

Type of practice/ Medical specialty: _____

Telephone: _____ Fax: _____

Medical Professional's Signature: _____

Please return this form to support the accommodation requested to: Wake Forest University Human Resources, attention: Benefits. Send by US mail to P.O. Box 7424, Winston-Salem, NC 27109 or by facsimile to (336) 758-6127, or via email to AskHR@wfu.edu