RICHMOND PUBLIC SCHOOLS
301 North Ninth Street • Richmond, VA 23219-1927
Americans with Disabilities (ADA) Office
ADA Coordinator: Timothy Williams
Email: adarequest@rvaschools.net

ADA Employee Accommodation Medical Certification

SECTION I: For Completion by the EMPLOYEE

Your Name: ____
First MI Last RPS Employee ID #

Your Job Title:_______________________________Work Location: __________________

Your Regular Work Schedule: ____

If you are an employee, please attach a copy of your official Richmond Public Schools Job Description to this document. You can find your Job Description here: https://www.rvaschools.net/Page/3602

SECTION II: For Completion by the HEALTH CARE PROVIDER

Instructions to the Physician

A request for a reasonable accommodation has been made by our employee, ______________________________________. In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer the questions on this form to help determine disability and reasonable accommodation.

Background

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such impairment. "Substantially limits" under the ADA Amendments Act (ADAAA) has been broadened to allow someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or expected duration less than or equal to six months.

The ADAAA provides examples of "major life activities," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

• PLEASE WRITE LEGIBLY • DO NOT LEAVE ANY LINES BLANK •

Today's Date: _

Healthcare Provider's Name (please print): ______________________________________

Type of Practice / Medical Specialty: ____

Business Address: ____

Phone:______________________________ Fax: ______________________________

Please answer these questions to help determine disability and reasonable accommodation:

1. Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties.) Is the employee able to perform the essential job functions of this position with or without reasonable accommodation? Yes ☐ No ☐

   ► If *yes,* please continue to next question.

   If *no*, how long will the employee be unable to perform these job duties?
   ______# of weeks ______# of months_______permanently

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SECTION II (cont.): For Completion by the HEALTH CARE PROVIDER

1. *Does the employee have a physical or mental impairment? Yes ☐ No ☐*
   ► *If yes, what is the impairment?*
   ____

2. *What limitation(s) is interfering with job performance, and how does it interfere with the employee's ability to perform the job function(s)?*
   ____
   ____

3. *What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?*
   ____
   ____

4. *The employee's typical schedule is* ______________________________
   What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position?
   ____
   ____

5. *How would your suggestions improve the employee's job performance?*
   ____
   ____

6. *How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated?*
   ____
   ____

7. *How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated?*
   ____
   ____

8. *Please include any additional comments or suggestions that would support us in understanding the disability and providing the appropriate accommodation if required:*
   ____
   ____

Healthcare Provider's Signature: ______________________ ***Date:*** ____/____/____

When the form is complete, please either:

Mail to: Richmond Public Schools, ADA Office,
301 North Ninth Street, 15th Floor, Richmond, VA 23219
Email: adarequest@rvaschools.net

FOR OFFICIAL OFFICE USE ONLY

Date received: ____/____/______

Received by: ______________________