WOONSOCKET EDUCATION DEPARTMENT

Americans with Disabilities Act (ADA)

Employee Accommodation Medical Certification Form

Section I: For Completion by EMPLOYEE

Name: _____
First MI Last

Job Title: _____ **Regular Work Schedule:** _____

Section II: For Completion by HEALTH CARE PROVIDER

Instructions to Health Care Provider

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

Provider Name (please print): _____

Type of Practice/Medical Specialty: _____

Business Address: _____

Phone: _____ Fax: _____

1. Please describe the medical condition for which the employee is seeking a leave of absence or accommodation.

_____

_____

_____

2. When did the medical condition begin? _____

3. How long is it expected to last? _____

4. IF the request is a leave of absence, will the leave of absence enable the employee to return to work? **Yes/No** (circle one). IF *Yes*, on what date do you anticipate the employee will be able to return to work? _____

5. Please review the attached job description (If no description is attached, please discuss the position with the employee to determine essential job duties and typical schedule). Upon return to work, will the employee be able to perform the essential functions of this position in a typical schedule with or without, reasonable accommodation? Please Check One.

☐ Yes, with reasonable accommodation ☐ Yes, without reasonable accommodation

☐ No, employee will be unable to perform essential job functions with or without accommodation

If *NO*, how long will the employee remain unable to perform these functions?

_____ # of weeks _____ # of months _____ permanently

If *YES*, what adjustments to the work environment or position responsibilities would enable the employee to perform these functions?

_____

_____

WOONSOCKET EDUCATION DEPARTMENT

Section II (continued): For Completion by HEALTH CARE PROVIDER **Employee: _____**

5. Please review the attached job description (If no description is attached, please discuss the position with the employee to determine essential job duties and typical schedule). Upon return to work, will the employee be able to perform the essential functions of this position in a typical schedule with or without, reasonable accommodation? Please Check One.

☐ Yes, with reasonable accommodation ☐ Yes, without reasonable accommodation

☐ No, employee will be unable to perform essential job functions with or without accommodation

If *NO*, how long will the employee remain unable to perform these functions?

_____ # of weeks _____ # of months _____ permanently

If *YES*, what adjustments to the work environment or position responsibilities would enable the employee to perform these functions?

_____

_____

If *YES*, how long will the employee need the reasonable accommodations to perform these job functions?

_____ # of weeks _____ # of months _____ permanently

6. Are there any accommodations, other than a leave of absence, that would enable the employee to perform the essential functions of the position? **Yes/No** (circle one)

If *YES*, what adjustments to the work environment or position responsibilities would enable the employee to perform these functions?

_____

_____

_____

7. Additional comments:

_____

_____

_____

Healthcare Provider Signature: _____ Date: _____

When form is completed please mail, fax, or email to: Human Resources, Woonsocket Education Department, 108 High Street Woonsocket, RI 02895 *401-767-4647 (fax)*mdargon@woonsocketschools.com