College of Southern Idaho
American Disability Act

Medical Certification

This section to be completed by the EMPLOYEE

Name of Employee (please print) _____

I hereby authorize the health care provider to release the following medical information for the purpose of determining compliance with the *American Disability Act.*

Employee's Signature _____ Date _____

This section to be completed by the HEALTH CARE PROVIDER:

Certification of Health Care Provider (ADA)

Attached for your review is the employee's job description which lists the essential functions of the employee's position. Please address the limitation(s), if any, to the essential functions that the employee is having difficulty performing due to his/her condition or treatments of the conditions.

Nature & severity of the employee's impairment: _____

_____

_____

Anticipated duration: _____

Major life activities substantially limited by the impairment: (e.g. walking, speaking, breathing, performing manual tasks, seeing, hearing learning, caring for oneself, sitting, standing, lifting or reading-activities that an average person can perform with little or no difficulty)

_____

_____

Work related restrictions that necessitate a reasonable accommodation for this employee.

_____

_____

Physician's Name (please print) _____

Address: _____

_____

Phone: _____

_____ _____

Signature of attending physician or practitioner Date