MERCER UNIVERSITY
HUMAN RESOURCES

Americans with Disabilities Act (ADA)
Medical Certification Form for Employee Accommodation Request

The information provided on this form must pertain only to the impairment(s) for which the employee is requesting accommodation under the Americans with Disabilities Act (ADA).

To be completed by Employee

Name: _____ MUID: _____

Position/Title: _____ Dept/Division: _____

By submitting this form to your healthcare provider, you authorize your provider to release this completed form, which may contain protected health information (PHI) as defined by HIPAA and similar state and federal laws, to the administrator(s) of the Americans with Disabilities Act for employees at Mercer University, as listed on page 3. You may rescind authorization at any time; however, failure to provide sufficient information necessary to evaluate your accommodation request may result in your request being denied.

Employee Signature: _____ Date: _____

To be completed by Health Care Provider

Instructions to the Health Care Provider: Please answer the following questions based on what limitations the employee has when their condition is in an active state and what limitations the employee would have if no mitigating measures were used. Completed forms should be returned directly to the contact at the bottom of this form.

1. Does the employee have a physical or mental impairment? ☐ Yes ☐ No
2. If yes, what is the impairment, including the nature and severity?

3. This impairment is *(check one):* ☐ Temporary ☐ Permanent
4. If not permanent, what is the estimated duration of the impairment?

From: _____ (mm/dd/yyyy) To: _____ (mm/dd/yyyy)

5. Does the impairment substantially limit a major life activity? ☐ Yes ☐ No

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) and/or major bodily function(s) is/are affected? *(check all that apply)*

Major life activities:		
☐ Bending ☐ Breathing ☐ Caring For Self ☐ Communicating ☐ Concentrating ☐ Eating ☐ Hearing ☐ Learning ☐ Lifting ☐ Performing Manual Tasks	☐ Reading ☐ Seeing ☐ Sitting ☐ Sleeping ☐ Speaking ☐ Standing ☐ Thinking ☐ Walking ☐ Working	☐ Other: (describe)
Major bodily functions:		
☐ Bladder ☐ Bowel ☐ Brain ☐ Circulatory ☐ Digestive ☐ Endocrine	☐ Immune system ☐ Neurological ☐ Normal Cell Growth ☐ Reproductive ☐ Respiratory	☐ Other: (describe)

6. Please briefly describe the extent to which the impairment(s) limits these activities/functions? *(For example: how many minutes per hour; frequency, weight restrictions, etc.,*)

7. What limitation(s), if any, is interfering or may interfere with the employee's ability to perform the essential functions of their position?

8. How does the employee's limitation(s) interfere with their ability to perform the essential functions of their position?

9. Based on this patient's medical history, do you have any suggestions for possible accommodations that would enable the employee to successfully perform the essential functions of their position? If so, please be specific.

10. Please provide any additional information relevant to the employee's impairment.

I certify that the information provided on this form is true and correct to the best of my knowledge.	
Health Provider Name (print)	**Title and Specialty**
Health Care Provider Address	**Telephone/Fax**
Health Care Provider Signature	**Date**

Return completed form to:

Candace Whaley
Associate Vice President for
Human Resources
Mercer University
Email: whaley_ce@mercer.edu

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