AMERICANS WITH DISABILITIES ACT

EMPLOYEE ACCOMMODATION MEDICAL CERTIFICATION FORM

Section I: For Completion by the EMPLOYEE

Employee Name_____University EID_____

Job Title_____Department_____

I authorize my licensed healthcare provider to complete this form for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act.

Employee Signature_____Date_____

Section II: For Completion by the HEALTHCARE PROVIDER

DEAR PHYSICIAN,

The above-referenced individual has identified you as the licensed health care provider who is treating the medical condition for which he/she is seeking reasonable accommodation. To assist us with this process, please complete this certification form. The individual should provide you with a copy of their job description. If no job description is available, please discuss the position with the individual to determine essential job functions. Please write legibly; if clarification is needed, the University's ADA Coordinators will contact you.

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

1. What is the individual's diagnosis?

2. Does the condition substantially limit a major life activity? If so, how?

3. Is the condition permanent? YES / NO

If NOT permanent, how long will the impairment likely last? _____ *# of weeks* _____*# of months*

4. Check the following that apply and indicate the degree of limitation in a typical 8-hour workday:

Please note that in a typical 8-hour workday: 65%= 5.2 hours and 33%= 2.64 hours.

Workday Activity	**Continuously limited,** individual *is limited* in this activity up to 65-100% of their workday.	**Frequently limited,** individual *is limited* in this activity up to 34-64% of their workday.	**Occasionally limited,** individual *is limited* in this activity up to 33% of their workday.	**Not at all limited,** individual has *no limitations* in this area
Sitting	□	□	□	□
Standing	□	□	□	□
Walking	□	□	□	□
Bending	□	□	□	□
Stooping, Kneeling, Squatting &Crouching	□	□	□	□
Climbing & Balancing	□	□	□	□
Concentrating	□	□	□	□
Hearing	□	□	□	□
Learning	□	□	□	□
Reading	□	□	□	□
Seeing	□	□	□	□
Speaking	□	□	□	□
Thinking	□	□	□	□
Remembering	□	□	□	□
Recognizing	□	□	□	□
Following Instructions	□	□	□	□
Working	□	□	□	□
Teaching	□	□	□	□

Workday Activity	**Continuously limited,** individual *is limited* in this activity up to 65-100% of their workday.	**Frequently limited,** individual *is limited in this activity up to 34-64% of their workday.*	**Occasionally limited,** individual *is limited in this activity up to 33% of their workday.*	**Not at all limited,** individual has *no limitations* in this area
Attend/Participate in Meetings	□	□	□	□
Attention Span	□	□	□	□
Analyzing	□	□	□	□
Interacting with Others (this includes students, co-workers and/or customers)	□	□	□	□
Driving (those who operate a UT vehicle as part of their job)	□	□	□	□
Lifting, Pushing or Moving 10 or less lbs.	□	□	□	□
Lifting, Pushing or Moving 10 – 20 lbs.	□	□	□	□
Lifting, Pushing or Moving 20 - 50 lbs.	□	□	□	□
Lifting, Pushing or Moving 50 - 80 lbs.	□	□	□	□
Lifting, Pushing or Moving over 80 lbs.	□	□	□	□
Reaching	□ Overhead □ Above Shoulders	□ Overhead □ Above Shoulders	□ Overhead □ Above Shoulders	□ Overhead □ Above Shoulders
Hand Function: Grasping and/or Squeezing	□ Left □ Right	□ Left □ Right	□ Left □ Right	□ Left □ Right
Hand Function: Writing and/or Holding a Pen/Pencil	□ Left □ Right	□ Left □ Right	□ Left □ Right	□ Left □ Right

Workday Activity	**Continuously limited,** individual *is limited in this activity up to 65-100% of their workday.*	**Frequently limited,** individual *is limited in this activity up to 34-64% of their workday.*	**Occasionally limited,** individual *is limited in this activity up to 33% of their workday.*	**Not at all limited,** individual has *no limitations* in this area
Hand Function: Typing and/or Operating a Mouse	□ Left □ Right	□ Left □ Right	□ Left □ Right	□ Left □ Right
Hand Function: Repetitive Hand or Wrist Motions (activities that involve twisting the wrist)	□ Left □ Right	□ Left □ Right	□ Left □ Right	□ Left □ Right
OTHER:(please explain)	□	□	□	□
OTHER:(please explain)	□	□	□	□

5. Describe any recommended accommodations. Be as specific as possible (i.e. a piece of office equipment or device, etc.)

□ Purchase of Assistive Device(s): _____

_____

□ Removal of Communications Barrier: _____

_____

□ Removal of Architectural Barrier:_____

_____

□ Modified Work Schedule:_____

_____

□ Job Restructuring (the University is **not** required to reallocate essential job functions):_____

_____

□ Ergonomic Assessment: _____

_____

□ Other:_____

_____

6. Describe how the requested accommodations will enable the individual to perform their essential job functions.

7. Please provide any other information that might help the University of Texas at Austin evaluate this request.

Section III: For Completion by the HEALTHCARE PROVIDER

I, the undersigned licensed healthcare provider, certify that the information I have provided regarding the above-referenced individual is complete and accurate to the best of my knowledge. I understand that my cooperation is necessary for the University of Texas at Austin to make an accurate determination regarding my patient's reasonable accommodation request.

Licensed Healthcare Provider's Signature	Date
Print Name	License No.
Phone Number	Fax Number
Email Address	Area of Practice

When form is complete, please return via fax to the attention of
The University of Texas at Austin, Office for Inclusion and Equity

Fax the form to: 512-471-8180

If you have questions, please contact: Stephanie Myers, Deputy ADA Coordinator at 512-471-7107 or smyers@austin.utexas.edu