Request for Workplace Accommodation
Certification of Physician or Health Care Practitioner

To be completed by the College employee:

Employee's full name: ________________________________

Please describe the workplace accommodation you are requesting and why: ________________________________

I authorize the following health-related information to be released to Franklin & Marshall College for the purpose of determining my ability to perform my essential job functions.

(Employee’s Signature) __________________ (Date) __________

To be completed by the employee’s health care provider:

1. Is the patient's health condition temporary or permanent? _____ Temporary (expected duration of 6 months or less) or _____ Permanent

2. If temporary, when is the patient expected to be fully recovered? ________________________________

3. In your professional opinion, does the above-named patient have a physical or mental impairment that substantially limits one or more Major Life Activities, without considering mitigating measures? _____ Yes _____ No

- Under the ADA, a person may be disabled if he or she has a physical or mental condition that substantially limits a major life activity (such as walking, talking, seeing, hearing, or learning).
- A person may be disabled if he or she has a history of a disability (such as cancer that is in remission).
A person may be disabled if he is believed to have a physical or mental impairment that is not transitory (lasting or expected to last six months or less) and minor (even if he does not have such an impairment).

4. If yes, please briefly describe the medical facts that support your conclusion:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

5. If yes, please describe which Major Life Activity(ies) is affected by the patient's impairment, and how:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

6. Is the patient able to safely perform all essential job duties as listed on his/her job description?
   _____ Yes   _____ No

7. Is an accommodation necessary to allow the patient to perform his/her essential job duties?
   _____ Yes   _____ No

8. If yes, please describe, in detail, the type of accommodation necessary to allow the patient to perform his/her essential job duties and the medical facts which support this request for an accommodation (please list all work restrictions):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

9. Is the employee totally disabled and unable to perform work of any kind? _____ Yes   _____ No
10. If yes, on what date was the patient first unable to work?

11. Estimated return to work date if applicable:

Name of Physician or Health Care Practitioner (please print)

Signature of Physician or Health Care Practitioner

Date

Name and Address of Practice

Phone Number

Health-related information provided on this form will be kept confidential in accordance with relevant federal and state laws.

Please return this completed form to Human Resources, Franklin & Marshall College, P.O. Box 3003, Lancaster, PA 17604-3003, or fax to (717) 291-3969.