CERTIFICATION OF HEALTH CARE PROVIDER FOR REASONABLE ACCOMMODATION OF DISABILITY UNDER THE AMERICAN WITH DISABILITIES ACT

Office of Human Resources ● PO Box 9701, McAllen TX, 78502 ● Phone: (956) 872-4448 ● Fax: (956) 872-4445

SECTION I: EMPLOYER INFORMATION

To Be Completed by EMPLOYER: Please complete **Section I** before providing this form to the Employee to be provided to the employee's physician or health care provider.

Employer's Name: ________________________________

Employer's Contact Person: _________________________ Title:_________________________

Address: ____ City: _____________ State: ______

Zip Code : ___________ Phone No. _______________ Email Address: __________________

SECTION II: CERTIFICATION OF PHYSICIAN OR HEALTHCARE PROVIDER

INSTRUCTIONS to the PHYSICIAN OR HEALTHCARE PROVIDER: Under the American with Disabilities Act (ADA) an employer may be required to provide reasonable accommodations to an otherwise qualified employee with a disability to enable the employee in performing the essential job functions of the employee's job when the employee's disability impedes or interferes with the employee's ability to perform such job functions. Under the ADA, "disability" is defined as a physical or mental impairment that substantially limits one or more major life activities of the employee. An impairment is substantially limiting if a person is unable to perform an activity as compared to an average person in the general population.

Your patient, the Employee, has requested a reasonable accommodation in his/her job under the American With Disabilities Act due to a claimed disability. A copy of your patient's request to the employer, South Texas College, is attached hereto. To support the request for reasonable accommodation, the Employee must provide the South Texas College with a written opinion from a licensed physician or qualified healthcare provider certifying the existence of a disability and the need for a reasonable accommodation.

To assist your patient, the Employee, in his/her request for reasonable accommodation, please answer all of the following questions fully. Your answers should be your best estimate based upon your medical training, knowledge, experience, and examination of the patient. You do not have to provide a diagnosis or prognosis, but be as specific as you can. Nebulous or non-specific answers may not be sufficient to determine eligibility for Sick Leave Pool leave.

A. <u>Physician Or Healthcare Provider Identifying Information</u>

1. Name of Physician/ Healthcare Provider: ______________________________________
2. Name of Practice: ______________________________________ Active license:______
3. License No._______________ State of Licensure: _______________
4. Type of practice / Medical specialty: ____
5. Physical Address: ____

6. Mailing Address: ____

7. Phone:________________ Fax:_______________ Email: _______________________

B. Facts Regarding Disability

1. Indicate whether you reviewed your patient's attached request for reasonable accommodation. ____ Yes ____ No.

2. Indicate whether you reviewed your patient's attached job description.___ Yes ___ No.

3. Does your patient have a physical or mental impairment that substantially limits one or more of your patient's major life activities? ____ Yes ____ No.

   If yes, please describe your patient's physical or mental impairment (you do not need to include a diagnosis or prognosis unless you have your patient's consent):

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4. Please indicate what major life activity (including major bodily functions) is/are substantially limited by your patient's physical or mental impairment:

___Bending	___Hearing	___Reaching	__ Other:
___Breathing	___Interacting With Others	___Reading	
___Caring For Self	___Learning	___Seeing	
___Concentrating	___Lifting	___Sitting	
___Eating	___Performing Manual Tasks	___Sleeping	
___Speaking	___Standing	___Thinking	
___Walking	___Working		

Major bodily functions:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	
☐ Circulatory	☐ Immune	☐ Operation of an Organ	☐ Other: ______

5. Is your patient's disability a permanent or temporary condition? ____________________

   If temporary, please state the date of onset and estimated duration of the disability:

   Onset Date:____________ Estimated duration:_________________

6. Is your patient's disability an episodic condition? _____ Yes _____ No.

   If yes, please describe the disability's episodic nature: _________________________

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C. Reasonable Accommodation Requested

1. Please state whether your patient's disability limits your patient's ability to perform any of the job functions set forth in the attached job description. ____ Yes _____ No.

2. If you answered “yes” to Question No. 1, please identify each job function in the job description which your patient has difficulty in performing due to the disability. For each job function identified, please state what reasonable accommodations should be made to assist your patient perform the job function.

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I certify that the information that I have provided in this certification is true and correct.

Physician’s Signature:___________________________________ Date:_________________