THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

MEDICAL CERTIFICATION OF AN A.D.A. QUALIFYING IMPAIRMENT

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ADA Coordinator Tammy Cope-Otterson
Human Resources and Employee Relations
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Employees requesting a reasonable accommodation pursuant to the Americans with Disabilities Act are asked to provide an appropriate health care professional with a copy of their job description, and then have the health care professional complete the following form certifying that the employee is eligible to receive an accommodation. *The information recorded on this form is confidential and should not be disclosed without proper authorization.* ***Please submit through the employee to the attention of: Tammy Cope-Otterson, Chief Officer, Human Resources Department.***

Authorization for Release of Medical Information

(to be completed by employee)

I authorize my physician or Health Care provider to release any information requested by my employer on this form or otherwise release of medical information is requested for process of my Request for an Accommodation for an ADA Impairment.

Employee/Applicant Signature: _____ Date: _____

Employee/Applicant Name: _____ ID #: _____

Home/Cell Phone Number: _____ Birth Date: _____

Employee/Applicant Address: _____

Medical Certification

(to be completed by physician or practitioner)

Nature and severity of the employee/applicant's impairment: _____

_____

Anticipated Duration: _____

Permanent or Long-Term Impact: _____

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*).

- ◯ No climbing
- ◯ No jumping
- ◯ No dancing
- ◯ No running
- ◯ No bending over
- ◯ No kneeling or squatting
- ◯ Must park close to worksite
- ◯ Must do sedentary/desk work ONLY
- ◯ No lifting with right/left upper extremity
- ◯ No lifting (greater than _____ pounds)
- ◯ No overhead lifting (greater than _____ pounds)
- ◯ No standing/walking (greater than _____ hours per day)
- ◯ No standing/walking (greater than _____ minutes without _____ minute rest)
- ◯ Other _____

Work tasks, duties or assignments specified on the job description or described by the employee which medically require reasonable accommodation for this employee: _____

Name of attending physician or practitioner (please print) _____

Address _____ Phone Number _____

Physician/Practitioner Signature _____ Date _____