North East Independent School District

Employee ADA Medical Certification

General Information:

The employee indicated on page two has requested an accommodation under the Americans with Disabilities Act (ADA/ADAAA), as amended, to enable the employee to perform the essential functions of his/her position. The information requested on this form will assist the ADA Coordinator in making a determination regarding the employee's request.

This is the initial step in processing an employee's request for a reasonable accommodation under North East ISD's policies and procedures. An accommodation is a reasonable modification or adjustment to the work environment that enables a qualified person with a disability to perform the essential functions of a position and enjoy equal access to all employment opportunities.

Having a medical condition alone is not enough to make an individual eligible for an accommodation under the ADAAA guidelines. Under the ADAAA, a person has a qualifying disability if the individual has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment. The ADAAA requires that North East ISD keep medical information confidential**.**

IMPORTANT NOTICE REGARDING GINA

Please read the information below before completing this form.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. ***In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information****. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Definitions:

A ***physical impairment*** is any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin or endocrine.

A ***mental impairmen***t is any physchological or mental disorder, e.g. mental retardation, organic brain syndrome, emotional or mental illness or specific learning disability.

A ***substantial limitation*** is defined as an impairment that prevents the performance of a major life activity that most people in the general population can perform.

A ***major life activity*** includes, but are not limited to:

a) Caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working; **and**

b) The operation of a major bodily function, including functions of the immune system, special sense organs and skin; normal cell growth; and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive functions. The operation of a major bodily function includes the operation of an individual organ within a body system.

Please submit completed forms by one of the following methods:

Email:	**U.S. Mail:**
accommodations@neisd.net Or **Fax:** (210) 805-2767	North East ISD Human Resources Department Attn: ADA Coordinator 8961 Tesoro Drive, Suite 200 San Antonio, Texas 78217

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Part 1: Employee Information and Release of Health Information

To be completed by **EMPLOYEE**

Employee Name		**D.O.B.**		**Employee ID**	
Job Title:		**Department:**			

I authorize my medical provider(s)_____

to release the following information from my patient file to the North East Independent School District for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).

Employee Signature:	**Date:**

Part 2: Work Status Information

To Be Completed by the **HEALTHCARE PROVIDER**

1. Please confirm you have examined the employee and are familiar with the employee's medical history? Yes ☐ No ☐

2. Please confirm you have reviewed the job description for the employee. Yes ☐ No ☐

3. Is the employee released to work full time, full duty without the need for restrictions, limitations, or accommodations? Yes ☐ No ☐

If Yes, please state the employee's full, Return to Work without restriction(s) date as of: _____.
(STOP – YOU DO NOT HAVE TO FILL OUT THE REMAINDER OF THIS FORM)

If No, please continue with Part 3 of this form.

Part 3: Existence of Impairment

To Be Completed by the **HEALTHCARE PROVIDER**

INSTRUCTIONS: The following must be completed in detail and signed by the employee's attending medical provider. Do not provide information not related to the employee's ability to perform his/her ability to perform his/her job duties**. EXAMPLE: Do not identify an impairment if it does not have an impact on employee's ability to perform his/her job duties.**

Attached are copies of the employee's job description which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. **Please review the attached job description and then complete and sign this form.**

Please see the definitions listed in the box on Page 1 for the words in **bold.**

Physician Name:		**Specialization / Type of Practice:**			
Address:		**Fax No:**		**Phone No.:**	

1. Does the employee have an **impairment** (physical or mental)?	Yes ☐	No ☐
2. Is this a condition which: **a.** requires periodic visits for treatment by a health care provider?	Yes ☐	No ☐

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	b. continues over an extended period of time?	Yes ☐	No ☐
	c. may cause episodic rather than a continuing period of incapacity?	Yes ☐	No ☐
	3. Does the employee have an impairment that **substantially limits** one or more ***major life activities***?	Yes ☐	No ☐

4. If the answer to # 3 is yes, which **major life activities** are affected?

Please check all major life activities below that both:
(a) are affected by the employee's impairment (s) and
(b) restrict or limit the employee's ability to perform the employee's job duties

To Be Completed by the **HEALTHCARE PROVIDER**

MAJOR LIFE ACIVITIES – General Life Activities

☐ Caring for Self	☐ Hearing	☐ Seeing	☐ Interacting with Others
☐ Thinking	☐ Working	☐ Performing manual tasks	☐ Sleeping
☐ Eating	☐ Breathing	☐ Speaking	☐ Toileting
☐ Concentrating	☐ Learning	☐ Other: _____	

MAJOR LIFE ACIVITITIES – Operation of Major Bodily Functions

☐ Bladder	☐ Operation of an Organ	☐ Immune	☐ Normal Cell growth
☐ Bowels	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Brain	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Circulatory	☐ Genitourinary	☐ Neurological	☐ Sensory organs & skin
☐ Other: _____			

5. If the answer to #3 and #4 is yes, please:

a. List what, if any, medications and/or other corrective measures that are currently prescribed to control or eliminate the individual's symptoms and/or limitations.

b. Describe how the impairment is mitigated and include information about any side effects that the individual experiences in light of the use of the medications and/or corrective measures outlined.

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Part 4: Physical Activity Restrictions

To Be Completed by the **HEALTHCARE PROVIDER**

☐ I certify that the employee has a **physical** impairment that limits one or more major life activity. Below are the life functions affected and the limitations of the employee.

Physical Activity	0	2	4	6	8	Other
Sitting	☐	☐	☐	☐	☐	
Standing	☐	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	☐	
Bending/Stooping	☐	☐	☐	☐	☐	
Climbing stairs/ladders	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Overhead Reaching	☐	☐	☐	☐	☐	
Kneeling/Squatting	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	
Keyboarding	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Lifting or Carrying:						
Max 10 lbs	☐	☐	☐	☐	☐	
Max 25 lbs	☐	☐	☐	☐	☐	
Max 50 lbs	☐	☐	☐	☐	☐	
Max 75 lbs	☐	☐	☐	☐	☐	
Max 100 lbs	☐	☐	☐	☐	☐	
Over 100 lbs	☐	☐	☐	☐	☐	
Repetitive Use of Hands:						
Right Only	☐	☐	☐	☐	☐	
Left Only	☐	☐	☐	☐	☐	
Both	☐	☐	☐	☐	☐	
Grasping/Squeezing:						
Right Only	☐	☐	☐	☐	☐	
Left Only	☐	☐	☐	☐	☐	
Both	☐	☐	☐	☐	☐	
Wrist Flexion/Extension:						
Right Only	☐	☐	☐	☐	☐	
Left Only	☐	☐	☐	☐	☐	
Both	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

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Part 5: Indicate Level of Mental, Emotional, and Sensory Limitations

To Be Completed by the **HEALTHCARE PROVIDER**

☐ I certify that the employee has a **mental/emotional** impairment that limits one or more major life activity. Below are the life functions affected and the limitations of the employee.

Manage Multiple Priorities	☐ Mild ☐ Moderate ☐ Severe	**Reasoning**	☐ Mild ☐ Moderate ☐ Severe
Intense Customer Interaction	☐ Mild ☐ Moderate ☐ Severe	**Hearing**	☐ Mild ☐ Moderate ☐ Severe
Multiple Stimuli	☐ Mild ☐ Moderate ☐ Severe	**Reading**	☐ Mild ☐ Moderate ☐ Severe
Frequent Change	☐ Mild ☐ Moderate ☐ Severe	**Analyzing**	☐ Mild ☐ Moderate ☐ Severe
Short-term Memory	☐ Mild ☐ Moderate ☐ Severe	**Verbal Communication**	☐ Mild ☐ Moderate ☐ Severe
Long-term Memory	☐ Mild ☐ Moderate ☐ Severe	**Written Communication**	☐ Mild ☐ Moderate ☐ Severe
Attention Span	☐ Mild ☐ Moderate ☐ Severe	**Vision**	☐ Mild ☐ Moderate ☐ Severe
Pace of Work	☐ Fast ☐ Average ☐ Below Average		

Part 6: Refer to Essential Functions Attachment when Answering these Questions

To Be Completed by the **HEALTHCARE PROVIDER**

Commencement of Impairments:

1. When did the employee's impairment(s) commence? If there is more than one impairment, please specify the start date of each:

Performance of Essential Job Functions:

2. Does the employee's impairment(s) limit his/her ability to perform the essential functions of the position (as defined in the job description), without an accommodation? Yes ☐ No ☐

a. **If Yes**, please identify which essential function (s) the employee is unable to perform without an accommodation.

b. Describe the manner in which the employee's ability to perform each essential function is limited.

Part 6: Refer to Essential Functions Attachment when Answering these Questions (Continued)

To Be Completed by the **HEALTHCARE PROVIDER**

Questions to help determine effective accommodation options.

3. Do you have any suggestions regarding possible accommodations to improve job performance? Include any equipment the employee may need to wear or use.

4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the medical condition? Yes ☐ No ☐

a. If yes, are the treatments or the reduced number of hours of work medically necessary?

Yes ☐ No ☐

b. If yes, please estimate treatment schedule/appointments, part-time or reduced work schedule.

5. If condition causes episodic flare-ups during these periods, will it be necessary for the patient to be absent from work? Yes ☐ No ☐

a. If yes, please provide the:

Frequency: _____ times per: _____ week(s) _____ month(s) _____ other

Duration: _____ hours or _____day(s) per episode

6. How would your suggestion(s) improve the employee's performance?

Note: Reasonable accommodations may include such things such as a modified schedule, provision of special equipment, workplace accessibility modifications, shifting of non-essential duties of the employee's position, and extended leave of absence to allow time for recovery, therapy, training, or other disability-related needs.

Part 6: Refer to Essential Functions Attachment when Answering these Questions (Continued)

To Be Completed by the **HEALTHCARE PROVIDER**

7. How long do you anticipate the employee will need the identified accommodation(s) to perform the essential job function(s)?

a. ☐ **Temporary**
The employee will return to work as of _____(date) with the restrictions identified in Part 4 which are expected to last through _____(date). Next follow up visit scheduled on: _____(date).

b. ☐ **Permanent**
The employee to return to work as of _____(date) with the restrictions identified in Part 4.

c. ☐ **Leave as a Reasonable Accommodation**
The employee is still prevented from returning to work as of _____(date) and is expected to continue through _____(date). Next follow up visit scheduled on: _____(date).

Additional Information

8. Are you aware of any other information that North East ISD should consider in assessing whether the employee can perform the essential job functions with or without accommodations?
Yes ☐ No ☐

If yes, please describe:

SIGNATURE of HEALTHCARE PROVIDER: *Stamps and Designee Signatures not Accepted*	**Date:**

ALL INFORMATION PROVIDED IS CONFIDENTIAL