PRIVATE AND CONFIDENTIAL

MEDICAL CERTIFICATION FOR REASONABLE ACCOMMODATION

Dear Health Care Provider:

[EMPLOYEE NAME] is currently employed by the Company as a [SPECIFY POSITION]. [EMPLOYEE NAME] is experiencing difficulty performing the essential functions of the job (see attached job description). The employee advises that some of his performance problems may be due to a medical condition. In light of this, please provide medical verification of the following:

_____**Accommodation is Not Necessary**. The employee is not suffering from a disability as defined by the Fair Employment and Housing Act (FEHA)/Americans with Disabilities Act (ADA), and an accommodation is not necessary. The employee is able to perform the essential functions of the job, and any inability to perform the essential functions of the job is not caused by his medical condition. My opinion is based on a review of the job description provided to me and/or a discussion with the employee of the job's essential functions.

_____**Accommodation is Recommended.** The employee is suffering from a disability as defined by the Fair Employment and Housing Act (FEHA)/Americans with Disabilities Act (ADA), which is impairing his ability to perform the essential functions of the job and an accommodation (which can include leave or an extension of leave) is recommended. My opinion is based on a review of the job description provided to me and/or a discussion with the employee of the job's essential functions.

- Please describe below, without specifying the employee's medical diagnosis, how the employee's physical or mental limitations impair the ability to perform the essential functions of the job and an indication of whether this temporary or permanent.

____

____

____

- If temporary, state when are the employee's physical or mental limitations expected to end:

____

- Please describe the recommended accommodation/s that will enable the employee to perform the essential functions of the job:

____

____

____

- Date proposed accommodation/s should begin:

____

- Estimated duration of accommodation/s (including length of leave if recommended as an accommodation):

____

- Additional Comments:

____
____
____
____

****
****

____

Health Care Provider's Name

____

Signature of Health Care Provider

Address of Health Care Provider:

____

____

Email: ______________________________

(___) ___-____ Telephone

(___) ___-____ Fax

This form must be returned to:

Company ________________________________

Representative ____________________________

Address ____________________________________

Email: ______________________________________

(___) ___-_____ Telephone

(___) ___-_____ Fax