CHICAGO STATE UNIVERSITY

American with Disabilities Medical Certification

Employee Section

Last Name: _____ First Name: _____ Employee ID # _____

Job Title: _____ Department: _____ Email: _____

Employee Signature: _____ Date: _____

To be completed by the Healthcare Provider

INSTRUCTIONS: 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.

Physician Name & License Number:	**Specialization / Type of Practice:**	

The questions below will help determine whether an employee has a qualifying disability. A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activities.

1. Does the employee have a physical or mental impairment? ☐ Yes ☐ No
2. What is the impairment? _____
3. Is the impairment permanent? ☐ Yes ☐ No
4. If **not** permanent, how long will the impairment likely last? _____
5. Is this condition considered a chronic condition which:
   a. Requires periodic visits for treatment by a health care provider? ☐ Yes ☐ No
   b. Continues over an extended period of time? ☐ Yes ☐ No
   c. May cause episodic rather than a continuing period of incapacity? ☐ Yes ☐ No
6. Does the impairment affect a major life activity? ☐ Yes ☐ No
7. If yes, what major life activity(s) is/are affected

☐ Caring for self	☐ Walking	☐ Hearing	☐ Lifting
☐ Interacting with others	☐ Standing	☐ Seeing	☐ Sleeping
☐ Performing Manual Tasks	☐ Reaching	☐ Speaking	☐ Concentrating
☐ Breathing	☐ Thinking	☐ Learning	☐ Working
☐ Toileting	☐ Sitting	☐ Reproduction	☐ Other: _____

8. Is the employee substantially limited in one or more of these major life activities? ☐ Yes ☐ No
9. Is the employee's limitation in any of these major life activities substantial? ☐ Yes ☐ No
10. Please indicate the severity of the condition(s): ☐ Mild ☐ Moderate ☐ Severe

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Refer to essential functions attachment when answering questions. The following questions will help determine if an accommodation is needed.	
To be completed by the Healthcare Provider	1. What limitation(s) in major life activities is/are interfering with the employee's job performance?
	2. What job function(s) listed in the job analysis is the employee having trouble performing because of the limitation(s)?
	3. How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the job functions listed in the attached job analysis?
The following questions will help determine effective accommodation options.	
To be completed by the Healthcare Provider	1. Do you have any suggestions regarding possible accommodations to improve job performance? If so what are they?
	2. How would your suggestion(s) improve the employee's performance?
	Comments:

Signature of healthcare provider Date:

(Stamps and Designee Signatures are NOT accepted)

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S MEDICAL FILE.

Completed forms should be returned to:
Chicago State University
Office of Human Resources, Cook ADM RM 203
Attn:
9501 S. King Drive
Chicago, Ill 60628