UF UNIVERSITY of FLORIDA

Accommodation Request Medical Certification Form

This form (or a similar letter on official letterhead that addresses the information requested) must be completed and signed by the treating healthcare provider when an employee needs a workplace accommodation due to a qualifying disability. Documentation should be sent to the UF ADA Office at adaservices@ufl.edu. The information provided will be reviewed to determine what reasonable accommodations, if any, are appropriate.

SECTION 1: COMPLETED BY THE EMPLOYEE

Employee Name: **UFID:**

Job Title: **Department:**

Job Duties:

SECTION 2: COMPLETED BY THE HEALTH CARE PROVIDER

1. Please describe the nature and severity of your patient's medical condition, including relevant medical facts related to the condition (e.g. symptoms, diagnosis, and regimen of treatment) and any functional limitations as it relates to the need for a workplace accommodation. (A workplace accommodation is any change or adjustment to a job or work environment that permits an employee with a disability to perform the essential functions of a job.)

2. Do you consider your patient's condition to be a disability? ◯ Yes ◯ No
   Under the ADA, a disability is a physical or mental impairment that substantially limits one or more of the major life activities (i.e. working, talking, hearing, seeing, thinking, communicating, caring for one's self, major bodily functions).

3. Please describe your recommendations for restrictions, modifications, or adjustments to the employee's job duties or work environment and explain how each will address the work-related information.

4. Please provide a timeline for these restrictions, modifications, or adjustments listed above.

◯ Temporary: ◯ Unknown:

◯ Indefinite (More than 6 months):

SECTION 3: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name/Practice:

Phone: **Fax:**

Signature: **Date:**