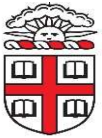

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Brown University: Americans With Disabilities Act (ADA) Accommodation(s) Request for Medical Certification

Instructions For Completing This Form

Employees should work with their Health Care Providers to complete this Request for Medical Certification. This form will assist Brown University in determining what accommodation(s), if any, could be provided to an employee to enable the employee to remain or return to work. The employee should complete and sign Part 1 of this form and then provide it to their Health Care Provider. The Health Care Provider should complete and sign Part 2 of this form and return it to either the employee or Broadspire Services Inc., the Third Party Administrator for Brown University. Employees must ensure this form is fully completed and returned within 15 calendar days of receipt.

NOTE: the information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA. Before completing this form, both the employee and Health Care Provider should review the GINA Compliance Notice that appears immediately below.

GINA Compliance Notification

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 an employee or family member of the employee, except as specifically allowed by this law. 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 employee's family medical history, the results of an employee's or family member's genetic tests, the fact that an employee or an employee's family member sought or received genetic services, and genetic information of a fetus carried by an employee or an employee's family member or an embryo lawfully held by an employee or family member receiving assistive reproductive services.

Part 1 To Be Completed By Employee

Employee Last Name: ___________________________ **Employee First Name:** _______________________________

Location: ___________________________ **Workday#** _______________ **Position:** _____________________________

I hereby authorize my medical provider(s) to complete this form for the purpose **of determining my eligibility for a reasonable accommodation under the Americans with Disability Act**. I further authorize Broadspire or Brown University to contact my medical provider(s) should any follow-up information or clarification be necessary.

Employee Signature ________________________________ **Date** ______________________________

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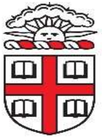

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Part 2 To Be Completed By Health Care Provider

In order to assist with the interactive process, we are requesting your responses to the following questions based on your medical expertise and treatment of the aforementioned employee. Please attach additional sheets if necessary.

1) Under ADA, an employee has a disability if they have a physical or mental impairment that substantially limits one or more major life activities or a record of such an impairment. Does the employee currently **have a physical or mental impairment** that substantially limits a major life activity (e.g. caring for one's self, performing manual tasks, walking, seeing, hearing, breathing, learning **and/or** working) and limits the employee's ability to perform the essential functions of their job?

Yes **No** **If yes**, please answer all of the following questions in entirety.

If no, skip to signature page.

Note to California Health Care Providers: Do not answer this question.

2) Please describe the nature and severity of the physical or mental impairment identified in Question 1 (including the limitations resulting from medication and/or other treatment) impacting the employee's ability to perform the essential functions of their job **as well as the expected duration of the impairment.**

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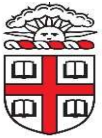

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3) Please list below the specific job duty(s) you believe the employee is unable to perform due to his/her impairment. Please identify the underlying functional restriction(s) which prevents the employee from performing the job duty, and identify the expected duration of each outlined restriction.

	Job Duty	**Underlying Functional Restriction(s) Impacting Job Duty**	**Duration Of Restriction(s)**
i			
ii			
iii			
iv			

4) Are there any reasonable accommodations you would suggest that may enable the employee to overcome the functional **limitations referenced above and thereby enable the employee to perform the job duty(s)? If so, please specify the reasonable accommodation and explain the factual and medical reasons why you believe the suggested accommodation** is likely to be effective in addressing the employee's functional limitations and note the estimated duration of the requested accommodation(s).

If the employee is not able to return to work, with or without accommodations at this time, and the accommodation suggested is a **continuous leave of absence**, please **specify below** and note the expected duration of the leave of absence.

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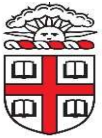

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5) Please describe how the suggested accommodation(s) will enable the employee to perform the essential function(s) of the position. If a **leave of absence** is suggested, please describe the treatment plan that will be in place during the requested leave and how it will allow the employee to return to performing the essential functions of the job if approved.

6) Please provide the **expected start and end date** for the above accommodation(s) requested. **PLEASE NOTE:** If the requested accommodation is for **intermittent time off**, please outline the expected frequency and duration, as well as the amount of time off being requested (e.g., 1-2 days off per month for up to 8 hours each day for incapacity for a period of 6 months and/or 1-2 days off per month to attend medical appointments for a period of 6 months).

____
Print Doctor's Name and Indicate Degree and Specialty

____
Print Address

____
Provide both phone and fax number (where we can reach you, if necessary)

____ ________________
Doctor's Signature **Date**

Return completed form to Broadspire Services, Inc., the Third Party Administrator for the employee's employer. Fax completed form to: {859-550-2744}, or mail to: PO BOX 14773 Lexington, KY 40512

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