Americans with Disabilities Act (ADA) Medical Certification Form

The University complies with the Americans with Disabilities Act of 1990 (ADA), as amended by the ADA Amendments Act of 2008, and other applicable federal and state laws and regulations that prohibit discrimination on the basis of disability.

Disability means, with respect to an individual, (1) a physical or mental impairment that substantially limits one or more major life activities of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment.

Under the ADA, a qualified employee with a disability may request reasonable accommodations by engaging in the interactive process with the University. As part of the interactive process, the University may request medical certification of the disability from the employee's treating healthcare provider. The treating healthcare provider will be asked about medical information relevant to the claim of disability and the major life activities the employee is unable to perform because of the disability. The healthcare provider will also be asked how the disability interferes with job performance or accessing a benefit of employment, as well as suggestions for accommodations to permit performance of essential job functions.

Once the need for accommodation becomes known, it is the responsibility of both the University and the individual with a disability to engage in a dialogue to identify possible accommodations and assess their reasonableness and effectiveness. Determinations regarding accommodations are made on a case-by-case basis.

Please submit the following form to your healthcare provider. Once complete, the provider may forward to the Office of Human Resources (OHR), via secure fax for medical records, at 410-704-6320.

If you have any questions about requesting an accommodation or the interactive process, please email adarequest@towson.edu or call the OHR at 410-704-2162.

Section 1 – for Completion by the Employee

Name: _____ Job Title: _____

Release of Information Agreement:

I, _____, authorize _____ to share this
(Employee Name) (Healthcare Provider)
information with Towson University. Additionally, I understand Towson University may contact this healthcare provider for further information or clarification of this document.

Employee's Signature: _____Date: _____

Section 2 – for Completion by the Healthcare Provider

The above employee has requested accommodation(s) under the Americans with Disabilities Act (ADA). To assist with the interactive process, please complete all of Section 2 and attach any appropriate supplemental documentation.

Healthcare Provider Name/Title: _____

Type of Healthcare Practice/Specialty: _____ Email: _____

Address and Phone Number: _____

To assist with the interactive process, we request your responses to the following questions based on your medical expertise and treatment of the aforementioned individual.

Questions to help determine whether an individual has a disability

1. Does the individual have a physical or mental impairment that substantially limits one or more major life activities or have a record of such an impairment? [☐ Yes] [☐ No] If yes, what is the impairment or nature of the impairment?

_____

_____

2. If yes, when did the impairment begin, how long is it expected to last, and what dates have you treated the patient for this condition?

_____

_____

3. Describe the individual's limitations when the impairment is active:

_____

_____

4. Does the impairment substantially limit a major life activity, including major bodily functions, as compared to most people in the general population?

☐ Yes ☐ No

Section 2 – continued – for Completion by the Healthcare Provider

5. If yes, what major life activities are affected?

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking	☐ Other: (describe)
☐ Breathing	☐ Interacting With Others	☐ Reading	☐ Standing	
☐ Caring For Self	☐ Learning	☐ Seeing	☐ Thinking	
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking	
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping	☐ Working	

What (if any) major bodily functions are affected?

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	☐ Other: (describe)
☐ Circulatory	☐ Immune	☐ Operation of an Organ	

Questions to help determine whether an accommodation is needed

6. What limitations interfere with the employee's job performance or accessing a benefit of employment?

_____

7. What job functions or benefits of employment is the employee having trouble performing or accessing because of the limitations?

_____

8. How does the employee's limitations interfere with their ability to perform the essential job functions or access a benefit of employment?

_____

Questions to help determine reasonable accommodation options

9. Given the limitations stated, do you have any suggested accommodations that would allow the employee to perform the essential job functions or access a benefit of employment? [☐ Yes] [☐ No] If yes, what do you suggest?

_____

10. If yes, how would these suggestions improve the employee's job performance?

_____

11. If yes, what is the likely duration of the employee's need for the suggested accommodation(s)?

_____

I certify I have treated the above individual, the individual is a current patient, and the information provided is accurate to the best of my medical knowledge.

Healthcare Provider's Signature: _____ Date: _____

Upon completion of this form, please fax to 410-704-6320. If you have any questions, please call 410-704-2162.

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 individual or family member of the individual, 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 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.