THE OHIO STATE UNIVERSITY

Accommodation Request Medical Certification

This form (or a similar letter that addresses the information requested) must be completed and signed by the treating health care provider when an employee needs a workplace accommodation due to a qualifying disability. **Documentation should be faxed to Office of Human Resources at 614-292-0271.** The information provided will be reviewed to determine what reasonable accommodations, if any, are appropriate.

SECTION 1: COMPLETED BY EMPLOYEE

Employee Name _____ Employee ID _____

Job Title _____ Department _____ Regular Work Schedule _____

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 functional limitations as it relates to their need for a workplace accommodation. *(A workplace accommodation is a modification to policy or practice, the provision of tools and software, or a modification to the environment that mitigates the impact of a disability to allow an employee to engage in work related tasks and activities.)*

   _____

   _____

2. Do you consider your patient's condition to be a disability? ❑ Yes ❑ No
   (Based on the Americans with Disabilities Act, a disability is defined as a mental or physical condition that substantially limits a major life activity compared to most people. "Substantial" in this context is somewhat subjective, but means that in your professional opinion there is a notable, significant, meaningful limit/difference to the manner in which the individual engages in the activity, the conditions necessary for them to engage in the activity, the duration for which they can engage in the activity, or the frequency which they engage in the activity. Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working and the proper functioning of major bodily systems.)

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 limitation.

   _____

   _____

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

   ❑ Temporary: _____ ❑ Indefinite *(expected to last longer than 6 months)*:_____ ❑ Unknown:_____

   If temporary, please provide the estimated end date for the restrictions. _____

5. Additional Comments: _____

   _____

   _____

SECTION 3: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name / Practice _____

Phone _____ Fax _____

Signature _____ Date _____