CERTIFICATION OF HEALTH CARE PROVIDER
FOR REASONABLE ACCOMMODATION

Patient's Name: _____

Date Condition Commenced: _____

Probable Duration of Condition: _____

This certification will be used for the purpose of assessing whether your patient has a disability that would benefit from a reasonable accommodation within the workplace. Please base your assessment on your patient's present abilities or limitations in performing the essential functions of his/her current position as described to you.

1. Does your patient have a disability?[1] ☐ Yes ☐ No

2. If you answered "yes" to question #1, is your patient able to perform each of the essential job functions described **without** reasonable accommodation(s)? ☐ Yes ☐ No

3. If you answered "no" to question #2, would your patient be able to perform each of the essential job functions described **with** reasonable accommodation(s)? ☐ Yes ☐ No

4. If you answered "yes" to question #3, please provide the following information: a) state which essential function(s) of the job require an accommodation; b) for each such essential function, state any recommendations you have for reasonable accommodation(s) and if there is more than one recommended accommodation, please describe all possible accommodations; c) explain why the disability requires this accommodation to allow the employee to perform the essential function(s).

[1] A disability is a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment. 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, and working. A major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Type the name and address of the Health Care Provider completing this form:

Name: _____

Address: _____

_____

_____

Telephone: _____

Facsimile: _____

E-mail Address: _____

_____ _____

Signature of Health Care Provider Date

THIS FORM SHOULD BE RETURNED DIRECTLY TO ORAL ROBERTS UNIVERSITY'S HUMAN RESOURCES DEPARTMENT AT HR@ORU.EDU.