Office of Human Resources
Employee & Labor Relations
550 S. College Ave, Suite 201
Newark, DE 19713
Phone: 302-831-2171
Email: employee-relations@udel.edu

EMPLOYEE ACCOMMODATION MEDICAL CERTIFICATION FORM

Section 1: Completion by Employee

First Name: ________________________ MI: ________ Last Name: ______________________

Employee ID: ____________________________ Job Title: ______________________________

Department: ____ Start Date: ________________

Direct Supervisor: ____________________________ HR Representative: __________________

Section 2: Completion by the Health Care Provider

A request for a reasonable accommodation under the ADA has been made by our employee. In order to assist with the interactive process, we a requesting you provide feedback to the following questions based on your medical expertise. Please follow the GINA guidelines below.

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.

1) Does the employee have a physical or mental health impairment? Yes ______ No ______

2) Describe the employee’s medical condition or impairment:

3) When did the medical condition begin, and how long is it expected to last?

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4) What are the limitations or restrictions on the employee's activities as a result of the condition and/or treatment of the condition?

5) Does the impairment substantially limit a major life activity? If yes, which major bodily functions are affected?

Bending	Hearing	Reaching	Speaking
Breathing	Interacting w/ Others	Reading	Standing
Caring for Self	Learning	Seeing	Thinking
Concentrating	Lifting	Sitting	Walking
Eating	Performing Manual Tasks	Sleeping	Working

Other (describe): ______________________________

Major Bodily Functions:

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

Other (describe): ______________________________

6) Are the functional limitations permanent? If not, what is the expected timeline for resolution?

Provider Name (Please print or type): ______________________________

Signature of Professional: ______________________________ Date: ______________

License No. ______________ State: ____________ Phone: ______________

Address — Street: ______________________________

City: ______________________ State: __________ Zip: __________

Email Address: ______________________________