



COMMONWEALTH UNIVERSITY OF PENNSYLVANIA

**Medical Certification Form**

400 East Second St., Bloomsburg, PA 17859 | [CUADA@commonwealthu.edu](mailto:CUADA@commonwealthu.edu) | Fax 570-389-5053

Note: The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the Americans with Disabilities Act (“ADA”).

**To be completed by Employee**

|              |                       |
|--------------|-----------------------|
| 1. NAME      | 2. JOB POSITION/TITLE |
| 3. SIGNATURE | 4. DATE               |

**To be completed by Health Care Provider**

The employee listed, above, is an employee of Commonwealth University of Pennsylvania. The employee has requested a reasonable accommodation for a disability and has identified you as their health care provider. The employee claims to have the following condition(s):

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and that this condition(s) requires a reasonable accommodation to enable them to perform the essential functions of their job. To assist the University in evaluating this request for accommodation, please provide detailed answers to the following questions, using additional sheets where necessary. The information you provide will be considered confidential and used only to evaluate the employee’s request for accommodation.

*Please return the completed form to the Commonwealth University ADA Coordinator:*

Email: [CUADA@commonwealthu.edu](mailto:CUADA@commonwealthu.edu)

Phone: (570) 389 5205

Fax: (570) 389 5053

***Please Note: 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 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.***

For reasonable accommodation under the ADA, an employee has a disability if the employee has an impairment that substantially limits one or more major life activities or a record of such an impairment.

1. Have you examined the employee for the above-stated condition? Yes \_\_\_\_\_ No \_\_\_\_\_  
Date of examination(s): \_\_\_\_\_
2. Does the employee have a “physical or mental impairment?” Yes \_\_\_\_\_ No \_\_\_\_\_
3. If you answered “yes” to question 2, please identify the employee’s specific physical or mental impairment (diagnosis):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Does the above-identified impairment substantially limit a major life activity of the employee? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Please indicate the approximate date when the employee’s condition or impairment began to substantially limit their ability to perform a major life activity.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. If you answered “yes” to question 4, please describe what major life activity(ies) is substantially limited.

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7. Please describe the manner and extent to which the impairment limits the above described major life activity(ies).

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8. What is your prognosis for whether and in what manner the impairment will continue to limit the above-described major life activity(ies)?

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9. What is the expected duration of the impairment?

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10. How does the impairment affect the employee’s ability to perform the essential functions of the employee’s job? (See attached job description). Please be specific.

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11. Please provide any additional medical information or documentation that you believe will assist the University in evaluating the impact of the employee's impairment; the activity or activities the impairment limits; and the extent to which the impairment limits the employee's ability to perform the activity or activities.

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12. Please list all reasonable accommodation(s) you believe would enable the employee to perform the essential functions of the employee's job.

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13. Please describe any functional limitations or restrictions that affect the employee's ability to perform the essential functions of their position. Examples may include limitations on lifting, standing, sitting, walking, or exposure to certain environments.

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Thank you for completing this Medical Certification Form. The University will use the information you have provided to evaluate the employee's request for reasonable accommodation.

|                         |                     |
|-------------------------|---------------------|
| 1. PROVIDER'S SIGNATURE | 2. DATE             |
| 3. PROVIDER'S NAME      | 4. TELEPHONE NUMBER |

### **Additional Information and Definitions**

Answers should reflect the impact of the symptoms when the patient's medical condition is in its active state **without regard to the ameliorative effects of mitigating measures such as:** medication; medical supplies; equipment or appliances; low-vision devices (devices that magnify, enhance or otherwise augment a visual image); prosthetics including limbs and devices; hearing aids and cochlear implants or other implantable hearing devices; mobility devices; oxygen therapy equipment and supplies; assistive technology; auxiliary aids or services (interpreters or other methods of making aurally delivered materials available to individuals with hearing impairments, qualified readers, taped texts, or other methods of making visually delivered materials available to individuals with visual impairments, acquisition or modification of equipment or devices); learned behavioral or adaptive neurological modifications.

Answers **should reflect** the impact of **ordinary eye glasses or contact lenses** that are intended to fully correct visual acuity or eliminate refractive error.

**\*1. Physical or mental impairment**

*The Americans With Disabilities Act (ADA) defines a physical or mental impairment as (1) any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin and endocrine; or (2) any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.*

**\*2. Substantially Limit**

*An impairment need not prevent or severely or significantly limit a major life activity to be considered substantially limiting. To have a disability an individual must be substantially limited in performing a major life activity as compared to most people in the general population.*

**\*3. Major Life Activity**

*The phrase "major life activity" includes, but is not limited to, functions such as caring for oneself, performing manual tasks, sitting, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working. Additionally, 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.*