Medical Certification Form

This medical certification is meant to facilitate documents of physical or mental disabilities and should be completed by the employee and his/her Physician. Please attach and sign additional pages that might clarify this request for accommodation.

Part 1 – To Be Completed by the Employee:

Employee Name:	Agency:
Job Title:	
I give authorization for my physician to release medical information to Franklin County Human Resources Department for the purpose of determining qualification and reasonable accommodation under the Americans with Disabilities Act.	
Employee Signature:	Date:

Part 2 – Medical Certification: To be Completed by the Employee's Physician:

Section A:

1.	Does the employee have a physical or mental impairment?	Yes ☐ No ☐
2.	If Yes, please describe the physical or mental impairment.	
3.	Is the impairment permanent?	Yes ☐ No ☐
4.	If not permanent, how long will the impairment likely last?	
5.	Is this a condition which:	
	a. Requires periodic visits for treatment by a health care provider?	Yes ☐ No ☐
	b. Continues over an extended period of time?	Yes ☐ No ☐
	c. May cause episodic rather than a continuing period of incapacity?	Yes ☐ No ☐
6.	Is the patient taking medications or treatments that would be expected to affect job performance that would pose a direct threat or safety risk?	Yes ☐ No ☐
	If yes, explain:	

7.	What activity or activities does the impairment limit?
8.	Additional comments or Requirements in regards to the impairment:

<u>Section B:</u> Please indicate the life function affected and the limitations of the employee <u>ONLY</u> if applicable.

Physical Activity	Mild Limitation	Moderate Limitation	Severe Limitation
Sitting			
Standing			
Walking			
Bending Over			
Climbing			
Reaching Overhead			
Kneeling			
Pushing & Pulling			
Crouching/Stooping			
Lifting or Carrying:			
• 10 lbs or less			
• 11 to 25 lbs			
• 26 to 50 lbs			
• 51 to 75 lbs			
• 76 to 100 lbs			
• Over 100 lbs			
Repetitive Use of Hands			
• Right Only			
• Left Only			
• Both			
Simple/Light Grasping			
• Right Only			
• Left Only			
• Both			
Firm/Strong Grasping			
• Right Only			
• Left Only			
• Both			
Fine motor, right hand			
Fine motor, left hand			

Indicate Level of Mental Emotional, and Sensory Limitations, if applicable.

Pace of Work	Fast ☐ Avg ☐ Below Avg ☐	Reasoning	Mild ☐ Moderate ☐ Severe ☐
Manage Multiple Priorities	Mild ☐ Moderate ☐ Severe ☐	Hearing	Mild ☐ Moderate ☐ Severe ☐
Intense Customer Interaction	Mild ☐ Moderate ☐ Severe ☐	Reading	Mild ☐ Moderate ☐ Severe ☐
Multiple Stimuli	Mild ☐ Moderate ☐ Severe ☐	Analyzing	Mild ☐ Moderate ☐ Severe ☐
Frequent Change	Mild ☐ Moderate ☐ Severe ☐	Verbal Communication	Mild ☐ Moderate ☐ Severe ☐
Short-Term Memory	Mild ☐ Moderate ☐ Severe ☐	Written Communication	Mild ☐ Moderate ☐ Severe ☐
Long Term Memory	Mild ☐ Moderate ☐ Severe ☐	Vision	Mild ☐ Moderate ☐ Severe ☐
Attention Span	Mild ☐ Moderate ☐ Severe ☐		

<u>Section C:</u> Please refer to Employee's Job Description when answering the questions below.

1.	Would the employee be able to perform the essential job functions listed in his/her job description with or without accommodation?
2.	If specific equipment may be needed in order for the employee to perform the essential functions of the job, please list what equipment might be needed:

Physician Name:	
Physician Address:	
Physician Phone Number:	
Physician's Signature:	