Accommodation Certification Form

Employer Contact: Carole Nelson, Director, Human Resources, Tel. (434) 245-2400
Fax. (434) 245-2603

Employee Name: ____________________________________________
Employee Job Title: __________________________________________
Employee’s essential job functions: See attached Job Description.

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To be completed by Health Care Provider:

Health Care Provider’s Name and Business Address: ____________________________
__________________________________________________________________________
__________________________________________________________________________

Type of Practice/Medical Specialty: __________________________
Telephone: (_____) _____________ Fax: (_____) ________________

I have reviewed the essential job functions/job description for this position and certify that employee: __________________________

_______ Is medically able to perform all essential functions of the position.

_______ Is medically unable to perform one or more essential functions of the position.

If the employee is unable to perform one or more of the essential functions of the position, please complete the following. Attach additional sheets if necessary.

Identify the job functions the employee is unable to perform: __________________________
__________________________________________________________________________
Identify the medical condition that renders the employee unable to perform such functions:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

State the expected duration of the medical condition:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Are there any accommodations that would enable the employee to perform the essential functions of the position? If so, please describe the accommodations and explain why the recommended accommodations are needed:

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Health Care Provider Signature

Date