CHARLOTTESVILLE CITY SCHOOLS

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.**

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:_____

_____

_____

_____

_____

_____

_____

_____

_____

Health Care Provider Signature Date