CHARLOTTESVILLE CITY SCHOOLS

ACCOMMODATION CERTIFICATION FORM

To be completed by employer:

Employer Contact: Dr. Keith P. Hubbard, Director of Human Resources

Employee's Name: _____

Employee's 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 speciality:

_____

Telephone number: _____ Fax number: _____

I have reviewed the essential job functions for the position and certify that

_____ **(Employee's name)**

Is medically able to perform all essential functions of the position

Is medically unable to perform all essential functions of the position

If the employee is medically unable to perform one or more of the essential functions of the position, 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? Is so, please describe the accommodations and explain why the recommended accommodations are needed: _____
_____
_____
_____
_____
_____
_____

_____

Signature of Health Care Provider Date