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: ____
____
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____
____

____
Signature of Health Care Provider   Date