



ADA PHYSICIAN'S STATEMENT

Employee's Name:	Job Title:	ID #:
Physician's Name:	Address:	Phone #:

INSTRUCTIONS: Please answer all of the questions below. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions if needed to answer more fully. When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the employee have a physical or mental impairment? <hr style="border-top: 1px dotted black;"/> If "yes", type of impairment:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the impairment substantially limit any major life activities? <hr style="border-top: 1px dotted black;"/> If "yes", which major life activity or activities are limited? <hr style="border-top: 1px dotted black;"/> For each major life activity that is limited by the impairment, please describe how the employee is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way in which an average person in the general population can perform that activity: <hr style="border-top: 1px dotted black;"/> What is the duration or expected duration of the impairment?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Can the employee perform all job functions in the attached job description/performance plan?</p> <p>If "no", which job functions cannot be performed, and why not?</p> <p>Please describe any reasonable accommodations that would allow this employee to be able to perform those job functions:</p> <p>If medical leave is one of the possible accommodations listed above, please provide an estimated duration for the leave:</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Would performing any of the job functions listed result in a direct safety or health threat to this employee or other people (co-workers, members of the general public, etc.)?</p> <p>If "yes", please describe which job function(s) would pose such a threat.</p> <p>Describe the direct safety or health threat posed:</p> <p>Describe any reasonable accommodations that would eliminate the direct safety or health threat, or reduce it to an acceptable level:</p>

Signature _____ Title _____ Date _____