NORTH EAST INDEPENDENT SCHOOL DISTRICT

Employee ADA Medical Certification

General Information:

The employee indicated on page two has requested an accommodation under the Americans with Disabilities Act (ADA/ADAAA), as amended, to enable the employee to perform the essential functions of his/her position. The information requested on this form will assist the ADA Coordinator in making a determination regarding the employee's request.

This is the initial step in processing an employee's request for reasonable accommodation under North East ISD's policies and procedures. An accommodation is a reasonable modification or adjustment to the work environment that enables a qualified person with a disability to perform the essential functions of a position and enjoy equal access to all employment opportunities.

Having a medical condition alone is not enough to make an individual eligible for accommodation under the ADAAA guidelines. Under the ADAAA, a person has a qualifying disability if the individual has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment. The ADAAA requires that North East ISD keep medical information confidential**.**

IMPORTANT NOTICE REGARDING GINA

Please read the information below before completing this form.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. ***To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information****. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Definitions:

A ***physical impairment*** is any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin or endocrine.

A ***mental impairmen***t is any physchological or mental disorder, e.g. mental retardation, organic brain syndrome, emotional or mental illness or specific learning disability.

A ***substantial limitation*** is defined as an impairment that prevents the performance of a major life activity that most people in the general population can perform.

A ***major life activity*** includes, but are not limited to:

a) Caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working; **and**

b) The operation of a major bodily function, including functions of the immune system, special sense organs and skin; normal cell growth; and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive functions. The operation of a major bodily function includes the operation of an individual organ within a body system.

Please submit completed forms by one of the following methods:

Email:	**U.S. Mail:**
accommodations@neisd.net Or **Fax:** (210) 805-2767	North East ISD Human Resources Department Attn: ADA Coordinator 8961 Tesoro Drive, Suite 200 San Antonio, Texas 78217

NORTH EAST INDEPENDENT SCHOOL DISTRICT

Employee ADA Medical Certification

TO BE COMPLETED BY THE EMPLOYEE

Part 1: EMPLOYEE Information and Release of Health Information

Employee Name	**D.O.B.**	**Employee ID**
Job Title	**Campus/ Dept:**	
With my signature below, I authorize my medical provider(s) listed below to release information from my patient file to the North East Independent School District for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).		
Employee Signature:		**Date:**

TO BE COMPLETED BY THE HEALTHCARE PROVIDER

Part 2: HEALTHCARE PROVIDER Information

Physician Name	**Specialization / Type of Practice**	
Address	**Phone #:**	**Fax #:**
Signature of Provider: (*Stamps and Designee Signatures are NOT accepted.)*		**Date***:*

Part 3: Work Status Information

Attached is a copy of the employee's job description which indicates essential functions of the position and includes physical/mental demands and environmental conditions associated with the job. Please review the attached job description; then complete and sign this form.

1. Have you examined the employee and are familiar with the employee's medical history?	Yes ☐	No ☐
2. Have you reviewed the job description for the employee?	Yes ☐	No ☐

3. Is the employee released to work full time, full duty without the need for restrictions, limitations, or accommodations?

☐ ***No***, please continue with Part 4 of this form.

☐***Yes***, please indicate when the employee may return to work without restriction(s): _____ (date)

(STOP – YOU DO NOT HAVE TO COMPLETE THE REMAINDER OF THIS FORM)

Part 4: Existence of Impairment – Sections 4-7 must be completed by the employee's medical provider.

Does the employee have a physical or mental impairment, or a record of such an impairment, that substantially limits one or more life activities?	Yes ☐	No ☐
If yes, what is the nature of the impairment? _____		
Does the employee's condition require periodic treatment by a health care provider?	Yes ☐	No ☐
Does the employee's condition continue over an extended period?	Yes ☐	No ☐
Does the employee's condition cause episodic periods of incapacity?	Yes ☐	No ☐
When did the employee's impairment(s) commence (approximately)? Date:		

Part 5: Please check all major life activities that are both <u>affected by the employee's condition and restrict the employee's ability to perform his/her duties.</u>

General Life Activities *Affected by Condition*	**Major Functions** *Affected by Condition*	**Posture and Motion Restrictions**		**Mental, Emotional and Sensory** *Limitations*
		Max hours per day	0 2 4 6 8	
☐ Caring for Self	☐ Bladder	Sitting	☐ ☐ ☐ ☐ ☐	Manage multiple priorities ☐ Mild ☐ Moderate ☐ Severe
☐ Thinking	☐ Bowels	Standing	☐ ☐ ☐ ☐ ☐	Intense customer interaction ☐ Mild ☐ Moderate ☐ Severe
☐ Eating	☐ Brain	Walking	☐ ☐ ☐ ☐ ☐	Multiple stimuli ☐ Mild ☐ Moderate ☐ Severe
☐ Concentrating	☐ Circulatory	Running	☐ ☐ ☐ ☐ ☐	Frequent change ☐ Mild ☐ Moderate ☐ Severe
☐ Hearing	☐ Operation of an Organ	Kneeling/squatting	☐ ☐ ☐ ☐ ☐	Short-term memory ☐ Mild ☐ Moderate ☐ Severe
☐ Working	☐ Digestive	Bending/stooping	☐ ☐ ☐ ☐ ☐	Long-term memory ☐ Mild ☐ Moderate ☐ Severe
☐ Breathing/Respiratory	☐ Endocrine	Pushing/pulling	☐ ☐ ☐ ☐ ☐	Attention span ☐ Mild ☐ Moderate ☐ Severe
☐ Learning	☐ Genitourinary	Twisting	☐ ☐ ☐ ☐ ☐	Pace of work ☐ Mild ☐ Moderate ☐ Severe
☐ Seeing	☐ Immune	Climbing stairs/ladders	☐ ☐ ☐ ☐ ☐	Reasoning ☐ Mild ☐ Moderate ☐ Severe
☐ Performing Manual Tasks	☐ Lymphatic	Reaching	☐ ☐ ☐ ☐ ☐	Reading ☐ Mild ☐ Moderate ☐ Severe
☐ Speaking	☐ Musculoskeletal	Overhead reaching	☐ ☐ ☐ ☐ ☐	Analyzing ☐ Mild ☐ Moderate ☐ Severe
☐ Interacting with others	☐ Neurological	May not lift/carry more than _____ lbs	☐ ☐ ☐ ☐ ☐	Verbal communication ☐ Mild ☐ Moderate ☐ Severe
☐ Sleeping	☐ Normal Cell Growth	Grasping/squeezing ☐ Right ☐ Left ☐ Both	☐ ☐ ☐ ☐ ☐	Written communication ☐ Mild ☐ Moderate ☐ Severe
☐ Toileting	☐ Reproductive	Wrist flexion/extension ☐ Right ☐ Left ☐ Both	☐ ☐ ☐ ☐ ☐	Hearing ☐ Mild ☐ Moderate ☐ Severe
☐ Driving/operating machinery	☐ Sensory Organs/Skin	Keyboarding	☐ ☐ ☐ ☐ ☐	Vision ☐ Mild ☐ Moderate ☐ Severe

Part 6: Please describe which essential functions (see job description) the employee is unable to perform without accommodation and suggest possible accommodations to improve job performance. Include any equipment the employee may need to wear or use. Attach additional pages if needed.

<u>ESSENTIAL JOB DUTY</u>	**<u>SUGGESTED/REQUESTED ACCOMMODATION</u>**

Part 7: Treatment, Episodic Flare-Ups, and Reduced Schedule

Will the employee need to attend follow-up **<u>TREATMENT OR SCHEDULED APPOINTMENTS</u>**? ☐ yes ☐ no **Estimated frequency of appointments:** _____ times per ☐ week or ☐ month **Estimated duration <u>per appointment:</u>** _____ ☐ hours or ☐ days	Will the employee's condition cause **<u>EPISODIC FLARE-UPS</u>** that will result in absence from work? ☐ yes ☐ no **Estimated frequency of episodes:** _____ times per ☐ week or ☐ month **Estimated duration <u>per episode:</u>** _____ ☐ hours or ☐ days	Will the employee need to work <u>PART-TIME</u> or on a **<u>REDUCED SCHEDULE</u>** because of his/her medical condition? ☐ yes ☐ no Max hours per _____ ☐ day or ☐ week

How long do you anticipate the employee will need accommodations to perform his/her job duties?

☐ ***Temporary -*** Employee may return to work as of _____(date) with restrictions through _____ (date)

☐ ***Permanent -*** Employee may return to work as of _____(date) with ***permanent*** restrictions.