FLORIDAPOLY

Florida Polytechnic University
Americans with Disabilities Act (ADA)
Disability Accommodation Certification

Section 1 – for Completion by the Requester (Employee)

Name: _____ Job Title: _____
(Employees Only)

Release of Information Agreement:

I, _____, authorize _____to share this
(Requestor name) (Medical Provider)

information with Florida Polytechnic University. Additionally, I understand Florida Polytechnic University may contact the medical provider for further information or clarification.

Requestor Signature: _____ Date:

Section 2 – for Completion by the Health Care Provider

The above individual has made a request for a reasonable accommodation. To assist with the interactive process, please complete this section and attach any appropriate supplemental documentation.

Medical Provider Name/Title: _____

Address: _____Email:_____

Phone Number: _____Type of Practice/Medical Specialty_____

1. Does this patient have a physical or mental impairment? _____ Yes _____ No
   If so, please identify/state the impairment.
   _____
   _____
2. When did the medical condition begin? _____
3. How long is it expected to last (is the condition permanent or temporary? If temporary, what is the expected duration of the condition)?
   _____
4. What dates have you treated the patient for this condition? _____
5. Describe the major life activities that are substantially limited by the medical condition or accompanying treatment:
   _____
   _____
   _____
6. How does the individual's limitation(s) interfere with their ability to perform the essential job functions or access a benefit of employment.
   _____
   _____
   _____

Section 2 – continued – for Completion by the Health Care Provider

7. What relevant accommodations do you recommend and why?

   _____

   _____

8. If your accommodation recommendation includes alteration to the work schedule, please complete below and indicate the reason for the alteration.

   Recommended work schedule: _____

   Length of work day (hours):_____Work days/hours per week: _____

   Breaks:

   _____ :

9. What is the duration of the condition/need for accommodation?

Additional comments:

I certify I have treated the above individual, the individual is a current patient, and the information provided is accurate to the best of my medical knowledge.

Medical Provider's Signature: _____ Date: _____
Printed Name of Provider: _____
Area of Practice/Specialty:_____
Telephone Number of Provider:_____
Address of Provider: _____

When this form is complete, please submit this form to hr@floridapoly.edu. If you have questions, please contact our Human Resources office at (863) 874-8425.

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 an individual or family member of the individual, except as specifically allowed by this law. 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 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.