## ADA CERTIFICATION

NOTE: The information sought on this form pertains only to the condition for which the employee is requesting accommodations under the ADA and the provisions of the ADAAA.

<table>
<thead>
<tr>
<th>To be completed by EMPLOYEE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Name:</td>
<td>TUid:</td>
</tr>
<tr>
<td>Job Title:</td>
<td>Department:</td>
</tr>
<tr>
<td>Employee Signature</td>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To Be Completed by the HEALTHCARE PROVIDER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Name:</td>
<td>Specialization / Type of Practice:</td>
</tr>
<tr>
<td>Address:</td>
<td>Fax No:</td>
</tr>
<tr>
<td>Phone No.:</td>
<td></td>
</tr>
</tbody>
</table>

**INSTRUCTIONS:** Attached are copies of the employee’s job description and a job analysis which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. Please review both the attached job description and job analysis and then complete and sign this form.

**Questions to help determine whether an employee has a qualifying disability.** A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activities.

1. Does the employee have a physical or mental impairment?  
   - Yes ☐  No ☐

2. What is the impairment?  

3. Is the impairment permanent?  
   - Yes ☐  No ☐

4. If not permanent, how long will the impairment likely last?  

5. Is this a condition which:
   - A. requires periodic visits for treatment by a health care provider?  
     - Yes ☐  No ☐
   - B. continues over an extended period of time?  
     - Yes ☐  No ☐
   - C. may cause episodic rather than a continuing period of incapacity?  
     - Yes ☐  No ☐

6. Is the patient taking medications or treatments that would be expected to affect job performance, that would pose a direct threat or safety risk?  
   (See attached job description for statement of duties)
   - Yes ☐  No ☐
   If yes, please explain

7. Does the impairment affect a major life activity?  
   - Yes ☐  No ☐

☐ I certify that the employee has a physical, mental, emotional, impairment that limits one or more major life activity. Below, please indicate the life function affected and the limitations of the employee.

<table>
<thead>
<tr>
<th>Physical Activity</th>
<th>Mild Limitation</th>
<th>Moderate Limitation</th>
<th>Severe Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bending Over</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Climbing
Reaching Overhead
Kneeling
Pushing & Pulling
Crouching/stooping

Lifting or Carrying
- 10 lbs or less
- 11 to 25 lbs
- 26 to 50 lbs
- 51 to 75 lbs
- 76 to 100 lbs
- Over 100 lbs

Repetitive Use of Hands
- Right Only
- Left Only
- Both

Simple/Light Grasping
- Right Only
- Left Only
- Both

Firm/Strong Grasping
- Right Only
- Left Only
- Both

Fine motor, right hand
Fine motor, left hand

**Indicate Level of Mental, Emotional, and Sensory Limitations**

<table>
<thead>
<tr>
<th></th>
<th>Fast</th>
<th>Avg</th>
<th>Below Avg</th>
<th>Reasoning</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Hearing</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Reading</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Analyzing</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Verbal Communication</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Written Communication</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Vision</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention Span</td>
<td>□ Mild</td>
<td>□ Moderate</td>
<td>□ Severe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Questions to help determine whether an accommodation is needed.**

1. What limitation(s) in major life activities is/are interfering with this employee's job performance?

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

2. What job function(s) listed in the job analysis is the employee having trouble performing because of the limitation(s)?

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

3. How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the job functions listed in the attached job analysis?

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

**Questions to help determine effective accommodation options.**

1. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

2. How would your suggestion(s) improve the employee's performance?

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

Comments:

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

**SIGNATURE OF HEALTHCARE PROVIDER:**

(Stamps and Designee Signature *NOT* accepted)

Date:

---

***ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE’S MEDICAL or PERSONNEL FILE***

**Return form to:**

Temple University Human Resources
Labor/Employee Relations
1852 North 10th Street;
Philadelphia, PA 19122

**Page 3 of 3**