THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA
Karyle Green, Ed.D.
Chief Human Resources Officer
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THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA
HEALTHCARE PROVIDER CERTIFICATION OF MEDICAL IMPAIRMENT

Employee Name and ID Number: _____

Home Address: _____

Telephone Number(s): _____

Work Location: _____

Current Job Title: _____

Clinic's Name: _____

Physician's Name: _____

Clinic's Address: _____

Clinic's Phone Number: _____

Clinic's Fax Number: _____

Dear Health Care Provider,

We are responding to your patient's request for an ADA Workplace Accommodation under the American with Disabilities Act. Your assistance in this process will be beneficial in assisting our employee. Please review the attached job description and respond to the following questions.

Thank you for your assistance.

Karyle Green, Ed.D.
Chief Human Resources Officer
The School District of Osceola County, FL

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THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FL
HEALTHCARE PROVIDER CERTIFICATION OF MEDICAL IMPAIRMENT

1. Identify each diagnosis to indicate whether chronic or acute; permanent or temporary; the severity; date of onset; and expected duration.

Diagnosis	Chronic or Acute	Permanent or Temporary	Severity (Mild, Moderate, Severe)	Date of Onset	Expected Duration

2. Does the employee's medical condition preclude or substantially limit the individual from performing any of the duties list on the enclosed job description. If so, identify which specific duties the employee is precluded from performing or substantially limited in his or her ability to perform due to medical necessity. For the purposes of this document and in accordance with guidance promulgated relative to the ADA, the definition of a substantial limitation means the employee would not be able to perform the task in a manner that would be comparable to that of the general population.

_____
_____
_____

3. Is there a medical reason to believe that the employee will experience injury, harm, or aggravation of his or her medical condition by attempting to perform the duties that you have provided in your response to number 2 above? Is so, what is the degree of injury, harm or aggravation that should be expected and what is the likelihood it may occur? What is the time frame in which it is likely to occur?

_____
_____
_____

4. Is the employee likely to recover sufficiently to perform the duties described in the attached job description? If so, what is the expected time frame for recovery? If not, what is the **medical reason** that would inhibit recovery?

_____
_____
_____

_____ _____

Physician's Signature **Date**

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