TENNESSEE STATE UNIVERSITY

*"Think. Work. Serve."*

Office of Human Resources
General Services, First Floor
3500 John Merritt Boulevard
Nashville, Tennessee 37209

# Employee ADA Reasonable Accommodation Medical Certification Form

## SECTION I: TO BE COMPLETED BY TSU EMPLOYEE

Full Name (First Name MI Last Name): _____

T Number: _____ Today's Date: _____

Job Title: _____

Department/ Division: _____ Total Work Hours/Week: _____

Typical Work Week Hourly Schedule: **M** ☐ **T** ☐ **W** ☐ **TH** ☐ **F** ☐ **S** ☐ **Su** ☐

*EXAMPLE: M 8-4:30 T 8-4:30 W 8-4:30 TH 8-4:30 F 8-4:30 S 0 Su 0*

## SECTION II: TO BE COMPLETED BY HEALTH CARE PROVIDER

*In accordance with the provisions of the Americans with Disabilities Act, as amended, the above-named employee has made a request for a reasonable accommodation for a disability. To assist us with this process, please complete the following information request. (All responses must be legible.)*

1. Does the employee have a physical or mental impairment?

   ☐ **No** ☐ **Yes** – If yes, what is the impairment?

   _____

2. Is the impairment permanent? ☐ **Yes** ☐ **No**

3. If the impairment is not permanent, for what period of time is the impairment expected to last? (Date of onset, expected duration)

   _____

   _____

   _____

4. Does the impairment affect one or more major life activities, including major bodily functions?

   ☐ **Yes** ☐ **No**

5. Please review the attached job description. (If the employee's job description is not attached, please discuss the position with the employee to determine essential job functions.) Is the employee able to perform the essential job functions with or without a reasonable accommodation?

   ☐ **Yes, without accommodation.** ☐ **Yes, with accommodation.**

   **No.** If no, for what period of time will the employee be unable to perform these job functions with or without a reasonable accommodation?

   _____

   _____

## SECTION II (CONTINUED): TO BE COMPLETED BY HEALTH CARE PROVIDER

6. How does the impairment limit the employee's ability to perform the essential job functions?

7. What adjustments to the work environment or position responsibilities would enable the employee to perform the essential job functions?

8. How would the suggested adjustments allow the employee to perform the essential job functions?

9. How long will the employee need the suggested adjustments to perform the essential job functions? If unable to provide a date, when is the employee scheduled for reevaluation?

Today's Date: _____

Health Care Provider Full Name: _____

Medical Specialization or Type of Practice: _____

Business Name: _____

Business Address: _____

Phone: _____ Fax: _____

Health Care Provider Signature: _____

## RETURN COMPLETED AND EXECUTED FORM TO:

Tennessee State University

Office of Human

Resources Fax:

615.963-7836

E-mail: hr@tnstate.edu

For Questions, call TSU Office of Human Resources at: 615.963.1237

Thank you.