Employee Accommodation Medical Verification Form
Americans with Disabilities Act (ADA) / ADA Amendments Act (ADAAA)

Georgia Southwestern State University is committed to providing reasonable accommodations to qualified individuals with disabilities in accordance with the ADA, ADAAA, applicable Board of Regents policies, and University System of Georgia guidance.

All medical information obtained through this process will be maintained separately from personnel records and shared only with those who have a legitimate business need to know.

SECTION I - EMPLOYEE INFORMATION (To Be Completed by Employee)

Employee Name: _____

Employee ID #: _____ Position Title: _____

Department: _____ Supervisor: _____

Accommodation Requested (if known):

Employee Authorization

I authorize my healthcare provider to release information regarding my medical condition, functional limitations, and accommodation needs to Georgia Southwestern State University for the purpose of evaluating my request for workplace accommodation under the ADA.

I understand that failure to provide sufficient medical documentation may limit the University's ability to evaluate my request.

Employee Signature: _____ Date: _____

SECTION II - ESSENTIAL JOB FUNCTIONS (To Be Completed by Human Resources and/or Supervisor)

Please list the essential functions of the position related to the accommodation request:

1. _____
2. _____
3. _____
4. _____

Position Description Attached: ☐ Yes ☐ No

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SECTION III - HEALTHCARE PROVIDER INFORMATION (To Be Completed by Treating Healthcare Provider)

Important GINA Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information except as specifically allowed by law. Please do not provide any genetic information, including family medical history, results of genetic testing, or information concerning genetic services.

Provider Name: _____ Specialty: _____
Practice Name: _____
Address: _____
Phone: _____ Fax: _____
Email: _____

Date of Most Recent Examination: _____

SECTION IV - MEDICAL CONDITION AND FUNCTIONAL LIMITATIONS

Is the employee under your care for a physical or mental condition that may qualify as a disability under the ADA? ☐ Yes ☐ No

If yes, identify the medical condition or diagnosis only to the extent necessary to explain the functional limitations:

Functional Limitations

Please describe the employee's functional limitations relevant to performing the essential functions of the position:

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Substantial Limitation

What major life activity or activities are substantially limited by the condition?

SECTION V - JOB IMPACT

Please review the essential job functions provided.

Are there essential job functions the employee cannot perform without accommodation?

☐ Yes ☐ No If yes, identify those functions:

Are there essential job functions that may be performed with accommodation?

☐ Yes ☐ No If yes, identify those functions:

Explain how the condition affects the employee's ability to perform the identified essential functions:

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SECTION VI - WORKPLACE RESTRICTIONS

Please indicate any workplace restrictions that are applicable.

Activity	None	Limited	Significantly Limited
Sitting	○	○	○
Standing	○	○	○
Walking	○	○	○
Lifting/Carrying	○	○	○
Reaching	○	○	○
Bending/Stooping	○	○	○
Hand/Finger Use	○	○	○
Concentration	○	○	○
Communication	○	○	○
Other	○	○	○

Describe any identified restrictions:

SECTION VII - EXPECTED DURATION

The employee's limitations are:

☐ Temporary ☐ Long-Term ☐ Permanent ☐ Episodic/Intermittent

Expected duration:

If episodic, please describe expected frequency and duration:

Do you anticipate the limitations will:

☐ Improve ☐ Remain Stable ☐ Worsen ☐ Unable to Determine

SECTION VIII - ACCOMMODATION RECOMMENDATIONS

What workplace accommodations, if any, do you recommend?

How would the recommended accommodations assist the employee in performing the essential functions of the position?

Are there alternative accommodations that should also be considered?

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SECTION IX - HEALTHCARE PROVIDER CERTIFICATION

I certify that the information provided on this form is accurate and based upon my examination, evaluation, and/or treatment of this individual.

Provider Signature: _____

Provider Printed Name: _____

Date: _____

Return Information

Office of Human Resources
Georgia Southwestern State University
800 Georgia Southwestern State University Drive
Americus, Georgia 31709

Phone: (229) 931-2000
Fax: (229) 931-2810

All medical information received will be maintained in a confidential medical file separate from personnel records.