BARRINGTON PUBLIC SCHOOLS

283 COUNTY ROAD, BARRINGTON, RI 02806

Americans with Disabilities Act (ADA)
Employee Accommodation Medical Certification Form

SECTION I: For Completion by EMPLOYEE

Name: _____
First MI Last

Job Title: _____

Regular Work Schedule: _____

SECTION II: For completion by HEALTH CARE PROVIDER

Instructions to Health Care Provider
A request for a reasonable accommodation has been made by our employee, _____.
In order to assist with our assessment of this request, we are requesting that you provide feedback to the following questions based on your medical expertise. Please answer the questions on this form to help determine disability and reasonable accommodation.

Provider Name (please print): _____

Type of Practice/Medical Specialty: _____

Business Address: _____

Phone: _____ Fax: _____

1. Please describe the medical condition for which the employee is seeking an accommodation.

   _____

   _____

2. When did the medical condition begin? _____

(continued on next page)

SECTION II (cont.): For completion by HEALTH CARE PROVIDER

3. How long is it expected to last? _____

4. Please review the attached job description. (If no description is attached, please discuss the position with the employee to determine essential job duties and typical schedule.) Is the employee able to perform the essential functions of this position in a typical schedule with, or without, reasonable accommodation?

   ☐ Yes, with reasonable accommodation ☐ Yes, without reasonable accommodation

   ☐ No, employee is unable to perform essential job functions with or without accommodation

   If *No*, how long will the employee remain unable to perform these job functions?

   _____ # of weeks _____ # of months _____ permanently

   If *Yes,* what adjustments to the work environment or position responsibilities would enable the employee to perform these job functions?

   _____

   _____

   If *Yes,* how long will the employee need the reasonable accommodation to perform these job functions?

   _____ # of weeks _____ # of months _____ permanently

5. Additional comments:

   _____

   _____

   _____

   _____

Healthcare Provider Signature: _____ Date: _____/ _____/ _____

When form is complete, please either: mail to Barrington Public Schools, PO Box 95, 283 County Road, Barrington, RI 02806; fax to (401) 245-5003; or email to gladneyn@barringtonschools.org