THE UNIVERSITY OF MEMPHIS

Certification of Physician
Americans with Disabilities Act (ADA) or
Pregnant Workers Fairness Act (PWFA) - CONFIDENTIAL

SECTION I: EMPLOYEE (PATIENT'S) INFORMATION

EMPLOYEE AUTHORIZATION: I authorize a representative of UofM's Human Resources Department to communicate directly with my health care provider for confirmation of the medical condition described below and clarification regarding my need for an ADA/PWFA accommodation.

Employee's name:_____ Medical Condition: _____

Employee's signature:_____ Date: _____

SECTION II: For Completion by the PHYSICIAN

The University needs to assess the condition of your patient in order to determine if he/she has a disability covered under the Americans with Disabilities Act/PWFA. In completing this form, you need to consider whether your patient has a physical or mental impairment that substantially limits one or more major life activities. Please answer questions, fully and completely; all applicable parts. Be as specific as you can and your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please be sure to sign the form on the last page.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Is this disability related to COVID-19? ☐ No ☐ Yes
2. Does the employee currently have a physical or mental impairment? ☐ No ☐ Yes
3. If yes, what is the nature and severity of the impairment?

4. Does the impairment substantially limit a major life activity? ☐ No ☐ Yes
5. If yes, what major life activity(s) is/are limited?

☐ Caring for self	☐ Walking	☐ Hearing	☐ Lifting
☐ Interacting with others	☐ Standing	☐ Seeing	☐ Sleeping
☐ Performing manual tasks	☐ Reaching	☐ Speaking	☐ Concentrating
☐ Breathing	☐ Thinking	☐ Learning	☐ Working
☐ Toileting	☐ Sitting	☐ Reproduction	☐ Other: _____

_____

_____

6. Does the impairment substantially limit a major bodily function? ☐ No ☐ Yes

7. If yes, what major bodily function(s) is/are limited?

_____

8. What is the prognosis as to the duration of her/his condition?

_____

9. Is the prognosis long-term or permanent? ☐ No ☐ Yes

10. For each condition listed in Item two (2) above, please provide the regimen of treatment to be prescribed, including number of visits, general nature and duration of treatment, and/or referral to another provider of health services. Please include the schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week:

Limitations/Restrictions: _____

Treatment: _____

11. Does the regimen of treatment tend to be less effective under certain circumstances?

_____

Or have limited effectiveness? _____

Schedule Number of visits: Per day: _____ Weekly: _____ Monthly: _____

12. Is inpatient hospitalization of the employee required? ☐ No ☐ Yes

13. Is the employee able to perform work of any kind? ☐ No ☐ Yes

Number of Hours able to work: Per day: _____ Weekly: _____ Monthly: _____

14. Please indicate how the condition impacts his/her ability to perform the essential job functions, and how long you anticipate the condition will last.

Essential Job Function	Limitation/Impact	Anticipated Duration

15. If the employee is not able to perform the essential function of his/her position, please list any accommodations that would enable the employee to perform each function:

_____ _____

Signature of Physician **Date**

PLEASE RETURN THIS FORM to **Human Resources, 165 Administration Building, Memphis, TN 38152**