Alachua County Public Schools

Division of Human Resources

REQUEST for MEDICAL STATUS EVALUATION under ADA

In order to make a determination about the nature of this employee's condition and whether the employee might be considered a qualified individual with a disability under the Americans with Disabilities Act (ADA), the Alachua County Public School system (ACPS) requests the following information from the individual's healthcare practitioner. This information is treated confidentially, is not maintained in the employee's main personnel file, and will be used only by authorized individuals with direct need to know and/or evaluate the information. Please return this form to:

Alachua County Public Schools
Alisha R. Williams, Human Resources
620 East University Ave.
Gainesville, Florida 32601

Phone (352) 955-7713
Fax (844) 318-2622

This section to be completed by employee:

Employee's Name	Soc. Sec. #	Date of Birth
Street Address City, State, ZIP		Day Phone Evening Phone
Place of Employment	Position	

In order for Alachua County Public Schools to evaluate my status with regard to a possible need for accommodation, my healthcare provider is authorized to disclose to Alachua County Public Schools my medical information, including any information regarding my physical and mental condition, and may provide additional clarification/information/documentation if requested. I, the undersigned, hereby authorize Alachua County Public Schools and its designated staff and administrators to obtain and receive all medical information related to me, including any supplemental information that may be requested, for the purpose of evaluating coverage and reasonable accommodation(s). I understand that if I refuse to provide requested medical information, my employer may decline my request for accommodation. This authorization is valid for one (1) year from the date of signature.

Employee's Signature:_____ Date:_____

This section to be completed by Healthcare Provider

Please print or type

Name of Physician/Practitioner	Specialty/Type of Practice
Office Address City, State, ZIP	Office Phone

1. Please state the patient's diagnosis and briefly describe the medical facts that support your certification.

   a) When did symptoms first appear?

   b) Subjective symptoms:

2. In your professional judgment, does this individual have, have a record of, or is regarded as having a physical impairment that is a physiological disorder, or condition, cosmetic disfigurement, or anatomical loss?

   Yes ☐ No ☐ If yes, please explain.

3. In your professional judgment, does the individual have a mental impairment that meets the following definition: "Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities"?

   Yes ☐ No ☐ If yes, please explain.

4. Under ADA regulations, major life activities are described as activities that an average person can perform with little or no difficulty. The regulations do not offer an exhaustive list but mention the following examples:

Sitting	breathing	working	standing
Seeing	caring for oneself	walking	hearing
performing manual task	speaking	learning	lifting
immune system	normal cell growth	digestive	bowel
bladder	neurological	brain	respiratory
circulatory	endocrine	reproductive	

In your professional judgment, does this individual have an impairment that limits one or more major life activities according to this definition?

Yes ☐ No ☐ If yes, please explain.

5. The limitation to major life activities must be substantial under the regulations, "An individual must be unable to perform, or be significantly limited in the ability to perform, the function." There are three factors to consider in determining whether a person's impairment substantially limits a major life activity:

   a) The nature and severity of the impairment

   b) How long the impairment will last or is expected to last

   c) The permanent or long-term impact or expected impact

   In your professional judgment, is the individual's impairment substantial?

   Yes ☐ No ☐ If yes, explain how the above factors individually or in combination substantially limit the individual in the performance of one or more major life activities.

6 a) If you believe the individual to have a disability that substantially limits the individual's ability to perform one or more major life functions, in your professional opinion, can the individual perform the essential functions of the job (based on the attached job description), with or without an accommodation, and without direct threat to their own health and safety and/or the health and safety of others in the workplace?

   Yes ☐ No ☐

   b) Is an accommodation required to enable the individual to perform the essential functions of the job as described?

   Yes ☐ No ☐

   c) If accommodation is required, can you suggest or recommend one or more possible reasonable accommodations that would specifically and directly address/ameliorate the substantial limitation and enable the individual to successfully perform the essential functions of the job?

   Yes ☐ No ☐ If yes, please suggest reasonable accommodations(s) and describe how such accommodation would enable the individual to perform the essential functions of the job:

7. a) In your professional judgment, can the individual's medical condition be successfully ameliorated with treatment (e.g. medication, diet, physical therapy, surgical treatment)?

   Yes ☐ No ☐

   If yes to 7a, is the individual compliant with your recommended course of treatment?

   Yes ☐ No ☐ If no, please explain in detail:

   _____

   _____

   _____

   b) If yes to 7a, is the individual compliant with your recommended course of treatment?

   Yes ☐ No ☐ If no, please explain in detail:

   _____

   _____

   _____

8. Regular attendance is an essential function of virtually all jobs, and an individual who cannot attend work regularly therefore may not qualify as "able to perform the essential functions of the position." In your professional judgment, does this medical condition create impairment that might ordinarily cause the individual to be unable to report to work in any substantive way?

   Yes ☐ No ☐ If yes, please describe:

   _____

   _____

   _____

9. Please provide any further information you feel would be useful to Alachua County Public Schools in evaluating the individual's medical condition.

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_____ _____

Physician's Signature Date

(Please do not use signature stamp or designee signature)

I have read the employee information letter provided by Alachua County Public Schools and the job description provided with this request. _____ *(Please initial)*