BAYLOR UNIVERSITY

Americans with Disabilities Act (ADA) Employee Accommodation Medical Certification Form BU-PP 415b

SECTION I: Fo	or Completion	by the EMPLOYEE			
Your Name:					
_	First	MI	Last	BU ID Number	
Your Job Title:	·				
Your Regular \	Work Schedule	:			
* If you are Staff, please attach a copy of your official Baylor Job Description to the back of this document. You can find your Job Description here: https://www1.baylor.edu/JobDescription/					
SECTION II: F	or Completion	by the HEALTH CARE PRO	OVIDER		
Instructions to	o the Physiciar	1			
A request for a reasonable accommodation has been made by our employee, In order to assist with the interactive process, we are requesting you to 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.					
Background					
An employee has a disability if he or she has an impairment that substantially limits one or more major life activities, or has a record of such an impairment. "Substantially limits" under the ADA has been broadened to allow someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or expected duration less than or equal to six months.					
oneself, perfo breathing, lea bodily functio	rming manual rning, reading, n, such as func	tasks, seeing, hearing, eat concentrating, thinking, o	ing, sleeping, walking, sta communicating, working, em, normal cell growth ar	vities," including "caring for anding, lifting, bending, speaking, and the operation of a major and digestive, bowel, bladder, ons."	
Provider Nam	e (please print):			
Provider Name (please print):					
Business Address:					
Phone:			Fax:		
				(continued next page)	

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Americans with Disabilities Act (ADA)

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SECTION II (cont.): For Completion by the HEALTH CARE PROVIDER					
1.	Does the employee have a physical or mental impairment? Yes No				
2.	Please describe the employee's medical condition.				
3.	When did the medical condition begin?				
4.	How long is it expected to last?				
5.	Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the medical condition or accompanying treatment.				
6a.	Please review the attached job description. (If no job 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, they are unable to perform their essential job functions with or without accommodation.				
6b.	If No, how long will the employee remain unable to perform these job functions?				
	# of weeks# of months permanently.				
6c.	If Yes, what adjustments to the work environment or position responsibilities would enable the employee to perform these job functions?				
6d.	If Yes, how long will the employee need the reasonable accommodation to perform these job functions? # of weeks # of months permanently.				
_					
7.	Additional Comments or Suggestions:				
Health	care Provider Signature: Date:				
When fo	rm is complete, please either: Mail to Baylor University, Human Resources, One Bear Place #97053, Waco, TX 76798-7053;				
If you ha	Fax to (254) 710-3819; or Email to <u>askHR@baylor.edu</u> ve questions, please contact: (254) 710-2000 or askHR@baylor.edu				