SAM HOUSTON STATE UNIVERSITY
EMPLOYEE DISABILITY ACCOMMODATION REQUEST
MEDICAL CERTIFICATION FORM*

Section I: For Completion by the EMPLOYEE

Employee Name_____

Sam ID_____

Job Title_____

Department_____

I authorize my licensed healthcare provider to complete this form for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act.

Employee Signature_____

Date_____

Section II: For Completion by the HEALTHCARE PROVIDER

DEAR PHYSICIAN,

The above-referenced individual has identified you as the licensed health care provider treating the medical condition for which he/she seeks a disability accommodation. To assist us with this process, please complete this certification form. Please write legibly; if clarification is needed, the University's Human Resources Department will contact you.

Please answer these questions to help determine disability and reasonable accommodation.

1. What is the individual's diagnosis?

2. Is the condition permanent? YES / NO

If NOT permanent, how long will the impairment likely last?___# of weeks_____# of months

3. Does the condition substantially limit a major life activity? If so, what activity and how?

*Submission of this form is not required for disability accommodation requests, however the information requested, including medical certification of the diagnosis, prognosis, limitations on major life activity(ies), and recommended accommodation must accompany a request.

4. Describe any recommended accommodations. Be as specific as possible (i.e. a piece of office equipment or device, etc.)

5. Describe how the requested accommodations will enable the individual to perform essential functions of the individual's job.

6. Please provide any other information that might help Sam Houston State University evaluate this request.

I, the undersigned licensed healthcare provider, certify that the information I have provided regarding the above-referenced individual is complete and accurate to the best of my knowledge. I understand that my cooperation is necessary for Sam Houston State University to make an accurate determination regarding my patient's disability accommodation request.

Licensed Healthcare Provider's Signature	Date
Print Name	License No.
Phone Number	Fax Number
Email Address	Area of Practice

When form is complete, please return via fax to the attention of
Human Resources Department, Sam Houston State University

Fax the form to: 936.294.3611

If you have questions, please contact: Human Resources at 936.294.1872