ADA MEDICAL CERTIFICATION FORM

PLEASE READ THE FOLLOWING BEFORE COMPLETING THIS FORM:

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.

The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA.

NOTE TO EMPLOYEES/PROVIDERS IN CALIFORNIA: In California, the Health Care Provider completing this form may not disclose the underlying diagnosis without the Employee/Patient's consent.

To be completed by **EMPLOYEE**			
	Employee Name		
	Job Title:	**Department:**	
	Employee Signature:		**Date:**

To be completed by **HEALTH CARE PROVIDER**			
	INSTRUCTIONS: Your patient has requested an accommodation in the workplace pursuant to the Americans With Disabilities Act (ADA). We need more information in order to determine if and how TeleTech can accommodate his or her request. Specifically, we need specific information about the functional limitations of your patient's medical condition and his or her need for reasonable accommodation. Attached is a copy employee's job description which identifies the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. **Please review the attached job description and then complete and sign this form. If you require any assistance or information, please contact:**		
	Physician Name (Please Print):	**Specialization/Type of Practice:**	
	Address:		**Phone #**

To be completed by **HEALTH CARE PROVIDER**	
	Questions to help determine whether an employee has a qualifying disability. A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activities. 1. Does the employee have a physical or mental impairment? Yes ☐ No ☐ 2. Is the impairment long-term or permanent? Yes ☐ No ☐ 3. If <u>not</u> permanent, how long will the impairment likely last? _____ _____

4. Does the impairment mean that the employee is substantially limited in one or more major life activities? Yes ☐ No ☐

5. If yes, what major life activity(s) is/are affected:

☐ 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	

☐ operation of a major bodily function: _____

To be completed by the **HEALTH CARE PROVIDER**

Questions to help determine whether an accommodation is needed.

How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the job functions listed in the attached job description?

Questions to help determine effective accommodation options.

1. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

2. How would your suggestion(s) improve the employee's performance?

Comments:

SIGNATURE OF HEALTHCARE PROVIDER:	**Date:**

*****ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S MEDICAL FILE*****