



Human Resources - Disability Services
 516 High Street, MS 5221, Bellingham, WA 98225
 360-650-3774 / fax 360-788-0071

**Medical Certification of Physician or Practitioner
 for a Reasonable Accommodation Request**

Employee Name:

Part A: Health Care Provider Verifies Employee's Disability

Does the employee have a sensory, mental, or physical impairment that is medically cognizable or diagnosable?
 (See reverse for complete State definition of disability.)
 Yes No

Please discuss job duties with employee or review their job description before proceeding.

Does this condition have a substantially limiting effect on the employee's ability to perform their job? A limitation is not considered substantial if it has only a trivial effect.
 Yes No

Part B: Health Care Provider Assesses Employee's Ability to Perform Job Duties

Due to the disabling condition, the employee is unable to perform the essential duties of their current position with or without reasonable accommodation.
 Yes No

Please list the employee's functional limitations due to their disabling condition.

Please list the job duties that should be reviewed for reasonable accommodation.

Part C: Health Care Provider Certifies Need for Requested Accommodation(s)

The employee has requested the following accommodations (to be completed by WWU if applicable):

Are these accommodations necessary and/or sufficient in terms of supporting the employee's disability and work limitations?

Yes No

Please list any accommodation or resource recommendations.

Part D: Health Care Provider Information:

Health Care Provider Name (PRINT):

Health Care Provider Signature:	Date:
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Type of Practice	Phone Number:
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Address: