

**Medical Certification Of Physician Or Practitioner
For A Reasonable Accommodation Request**

Employee Name:

Part A: Medical Verification Of A Disabling Condition

Does the employee have an abnormal sensory, mental, or physical condition that is medically cognizable or diagnosable?

Yes No

Does this condition substantially limit the employee's ability to perform his/her job? (see attached job description or discuss job duties with employee) Yes No

Please list the employee's functional limitations due to his/her disabling condition:

Date Condition Commenced:

Probable duration of condition/limitations:

Part B: Assessment Of Employee's Ability To Perform Job Duties:

Please check all that apply:

Due to the disabling condition, the employee is unable to perform the essential duties of his/her current position with or without reasonable accommodation.

Reasonable accommodations should be considered for the employee to perform some or all of the essential functions of his/her job. Please list the job duties that should be reviewed for reasonable accommodation or mark on the job description attached:

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 C: Health Care Provider Information:

Health Care Provider Signature:

Health Care Provider Name (PRINT):

Date:

Address and Phone Number:

Type of Practice: