Office of Human Resources | West Chester University
201 Carter Drive, Suite 100 | West Chester, PA 19383 | 610-436-2800 | fax: 610-436-3464 | www.wcupa.edu

Medical Certification Form

Note: The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the Americans with Disabilities Act ("ADA").

To be completed by Employee

1. NAME	2. JOB POSITION/TITLE
3. SIGNATURE	4. DATE

To be completed by Health Care Provider

The employee listed, above, is an employee of West Chester University of Pennsylvania. The employee has requested an accommodation for a disability and has identified you as their health care provider. The employee claims to have the following condition(s):

_____

_____

and that this condition(s) requires an accommodation to enable them to perform the essential functions of their job. To assist the University in evaluating this request for accommodation, please provide detailed answers to the following questions, using additional sheets where necessary. The information you provide will be considered confidential and used only to evaluate the employee's request for accommodation.

Please return the completed form to ADA@wcupa.edu *within 10 business days.*

Please Note: 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 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

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embryo lawfully held by an individual or family member receiving assistive reproductive services.

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For reasonable accommodation under the ADA, an employee has a disability if the employee has an impairment that substantially limits one or more major life activities or a record of such an impairment.

1. Have you examined the employee for the above-stated condition? Yes _____ No _____
   Date of examination(s): _____

2. Does the employee have a "physical or mental impairment?" Yes _____ No _____

3. If you answered "yes" to question 2, please identify the employee's specific physical or mental impairment (diagnosis):
   _____
   _____
   _____
   _____
   _____

4. Does the above-identified impairment substantially limit a major life activity of the employee?

   Yes_____ No_____

5. If you answered "yes" to question 4, please describe what major life activity(ies) is substantially limited.
   _____
   _____
   _____
   _____
   _____

6. Please describe the manner and extent to which the impairment limits the above described major life activity(ies).
   _____
   _____
   _____
   _____
   _____

7. What is your prognosis for whether and in what manner the impairment will continue to limit the above-described major life activity(ies)?
   _____
   _____

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_____
_____
_____

8. What is the expected duration of the impairment?

_____
_____
_____
_____
_____

9. How does the impairment affect the employee's ability to perform the essential functions of the employee's job? (See attached job description). Please be specific.

_____
_____
_____
_____
_____

10. Please provide any additional medical information or documentation that you believe will assist the University in evaluating the impact of the employee's impairment; the activity or activities the impairment limits; and the extent to which the impairment limits the employee's ability to perform the activity or activities.

_____
_____
_____
_____
_____

11. Please list any accommodation(s) you believe would enable the employee to perform the essential functions of the employee's job.

_____
_____
_____
_____
_____

Thank you for completing this Medical Certification Form. The University will use the information you have provided to evaluate the employee's request for accommodation.

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1. PHYSICIAN'S SIGNATURE	2. DATE
3. PHYSICIAN'S NAME	4. TELEPHONE NUMBER