Reasonable Accommodation
Certification From Physician/Health Care Provider

Employee Name		**Date**	

ACWA JPIA is requesting a certification from a health care provider verifying that an accommodation is necessary. *(An employer may request this information when the employee's disability or need for accommodation is not apparent or known.)*

Attached is a list of the essential functions for _____ (Employee Name)

For the job title: _____

Please provide a letter or verification addressing the following:

1. Verification that the employee has a disability (but not the diagnosis).
2. Description of how the employee's limitations impair the ability to perform the duties of the job (See attached list of essential functions).
    a. Indicate whether these limitations are temporary or permanent.
    b. If temporary, state when they are expected to end.
3. Recommendation of specific reasonable accommodation(s) that would allow the employee to perform the essential functions of the job.
    a. If no accommodation is necessary, please indicate.

Use the space below or attach a letter or verification, which will be kept confidential.

Date Accommodation to Begin _____ Date Accommodation to End or Continuous _____

Health Care Provider Information:

_____

Name of Health Care Provider

_____

Address

_____ _____ _____

City State Zip Code

_____

Telephone

_____

Health Care Provider Signature