Americans with Disabilities Act (ADA) Employee Accommodation Medical Certification Form

The information provided on this form must pertain only to the condition for which the employee is requesting accommodation under the ADA.

To be completed by the EMPLOYEE

Name: ____

Job Title: ____

Regular Work Schedule: ____

I hereby authorize ______________________________, my health care provider, to release the requested medical information to JEM Wellness Brands, LLC for purposes of determining qualification and reasonable accommodation under the ADA.

Employee Signature: ______________________________________ Date:____________

To be completed by the HEALTH CARE PROVIDER

Instructions to the Health Care Provider: A request for a reasonable accommodation has been made by the above-named employee. In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer the questions on this form to help determine disability and reasonable accommodation.

Provider Name (please print): ____

Type of Practice/Medical Specialty: ____

Business Address: ____

Phone: ________________________________ Fax: ___________________________________

1. Does the employee have a physical or mental impairment?[1] ☐ Yes ☐ No

   (If the answer is "no," stop here)

2. If yes, please describe the physical or mental impairment.

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[1] Do not answer "yes" to this question if the impairment is a sexual behavior disorder such as pedophilia or exhibitionism, compulsive gambling, kleptomania, pyromania or a psychoactive substance use disorder resulting from current illegal use of drugs.

3. When did the medical condition begin? ____
4. How long is it expected to last? ____

5. Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the medical condition or accompanying treatment. Write "none" if the condition or treatment does not affect any major life activity.

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Questions to help determine whether an accommodation is needed.

6. (a) Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties and typical schedule).

   Is the employee able to perform the essential functions of this position in a typical schedule with, or without, reasonable accommodation?

   ☐ Yes, with reasonable accommodation ☐ Yes, without reasonable accommodation

   ☐ No, they are unable to perform their essential job functions with or without accommodation

   (b) If ***NO***, how long will the employee remain unable to perform these job functions?

   ___________ # of weeks ___________ # of months ☐ Permanently

   (c) If ***YES***, what adjustments to the work environment or position responsibilities would enable the employee to perform these job functions?

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   (d) If ***YES,*** how long will the employee need the reasonable accommodation to perform these job functions?

   ___________ # of weeks ___________ # of months ☐ Permanently

7. Additional Comments or Suggestions:

   ____

   ____

Health Care Provider Signature: ____

Date: ___________________________________

When form is complete, please either:

1. Email to hr@jembrands.com
2. Fax to (470) 447-1762

If you have questions, please contact: HR at hr@jembrands.com