

Ohio Department of Job and Family Services

Instructions for Application

- ❖ The attending physician must complete Sections I through VII without expense to the State of Ohio.
- ❖ Please print legibly or type.
- ❖ Each section should be completed as thoroughly as possible. Failure to fully complete may result in a denial of the employee's request for accommodation.
- ❖ Attending physician should retain a copy of all pages of form.
- ❖ The employee is responsible for returning the entire form to the Bureau of Civil Rights.
- ❖ Please be certain to review the attached position description and summary of work environment/duties before completing this form.

Attending Physician Statement for ADA Accommodation

Employee's Name	Social Security Number
Section I - HISTORY OF ADA CONDITION(S)	
Date you rendered this patient disabled under the ADA.	
Date first consulted you for this condition.	Additional dates of treatment including the most recent visit.
Frequency of visits <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	Is condition due to injury or sickness arising out of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Section II - DIAGNOSIS	
Give complete diagnosis	
Describe fully any complications	
Section III - PRESENT CONDITION **PLEASE COMPLETE IN DETAIL**	
Subjective symptoms (describe fully)	

Objective findings: List all pertinent findings and attached available medical evidence to support claim. **Insufficient evidence may result in disapproval.**

Describe mood and affect, ability to carry out daily activities, follow instructions, judgment, and ability to concentrate.

Is there evidence of a thought disorder or impairment in memory?

Comment on how the combined symptoms and intensity interfere with job performance.

Is there evidence that the employee poses a direct threat? (A significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation).

List medications currently prescribed.

Section IV - PROGNOSIS

Do you expect marked change in the future? Yes No Comment as to nature of continuing treatment and progress.

Section V - SUGGESTED ACCOMMODATIONS

What restrictions are placed on patient's work activities?

Please list your recommended accommodation(s). (BE SPECIFIC)

Section VI - REMARKS

Additional Remarks

Section VII - PHYSICIAN SIGNATURE

Name (attending physician) Please print

Specialty

Federal ID #

Street Address

City

State

Zip Code

Telephone Number

Date form received

Date signed

Signature

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, or other medical or medically-related facility having information available as to diagnosis, treatment, prognosis, and suggested accommodation(s) with respect to any physical or mental condition and/or treatment of me to release and provide such information to my employer, the Ohio Department of Job and Family Services.

Further, **I AUTHORIZE** the Ohio Department of Job and Family Services to clarify any information provided by my Health Care Provider.

I UNDERSTAND that information obtained with this Authorization will be used by the Ohio Department of Job and Family Services to determine whether I am covered under the Americans with Disabilities Act (ADA). Any information obtained will not be released to any person or organization except to those persons or organizations performing business or legal services in connection with this claim or as may be lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photocopy of this Authorization will be as valid as the original.

I AGREE that this Authorization shall be valid indefinitely.

Signature	Date
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The Ohio Department of Job and Family Services requires a medical certification of an individual's disability as defined in the ADA. The Ohio Department of Job and Family Services reserves the right, at its own expense, to seek a second medical opinion at any time, if deemed necessary.