

**PINELLAS COUNTY SCHOOLS
REQUEST FOR
MEDICAL STATUS EVALUATION under ADA**

In order to make a determination about the nature of this employee's medical condition, and whether the employee might be considered a qualified individual with a disability under the Americans with Disabilities Act (ADA), Pinellas County Schools (PCS) requests the following information from the individual's healthcare practitioner. This information is treated confidentially, is not maintained in the employee's main personnel file, and will be used only by authorized individuals with direct need to know and/or evaluate the information. Please return this form to:

Pinellas County Schools
Human Resources Department
Attention - ADA
301 4th St. SW
Largo, FL 33770
Email: pcsleaves@pcsb.org
Fax: (727) 588-5001

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

| | | |
|--|--------------------|---------------|
| Employee's Name | Soc. Sec. # | Date of Birth |
| Street Address City, State, ZIP | Day Phone | Eve Phone |
| Place of Work | Position | |
| In order for Pinellas County Schools to evaluate my status with regard to possible need for accommodation, my healthcare provider may release this information and may provide additional clarification/information/documentation if requested by PCS. | Employee Signature | |

PLEASE PRINT OR TYPE

THIS SECTION & FORWARD TO BE COMPLETED BY HEALTHCARE PROVIDER:

| | |
|------------------------------------|-----------------------------------|
| Name of Physician/Practitioner | Degree/Specialty/Type of Practice |
| Office Address City, State, ZIP | Office Phone |

1. Please state the patient's diagnosis and briefly describe the medical facts that support your certification.

a) When did symptoms first appear? _____

b) Subjective symptoms: _____

2. In your professional judgment, does this individual have a *physical impairment* that is a physiological disorder, or condition, cosmetic disfigurement, or anatomical loss?

Yes No

If yes, please explain. _____

3. In your professional judgment, does the individual have a *mental impairment* that meets the following definition: “Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities?”

Yes No

If yes, please explain. _____

4. Under ADA regulations, *major life activities* are described as activities that an average person can perform with little or no difficulty. The regulations do not offer an exhaustive list but mention the following examples:

- ◆ sitting
- ◆ breathing
- ◆ working
- ◆ bending
- ◆ thinking
- ◆ standing
- ◆ seeing
- ◆ caring for oneself
- ◆ reading
- ◆ communicating
- ◆ walking
- ◆ hearing
- ◆ performing manual tasks
- ◆ concentrating
- ◆ speaking
- ◆ learning
- ◆ lifting
- ◆ interacting with others
- ◆ major bodily functions (e.g., “functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions”)

In your professional judgment, does this individual have an impairment that *limits one or more major life activities* according to this definition?

Yes No

If yes, please describe. . _____

5. The limitation to major life activities must be substantial under the regulations: “An impairment is substantially limiting if it prohibits or significantly restricts an individual’s ability to perform a major life activity as compared to the ability of the average person in the general population to perform the same activity.” There are three factors to consider in determining whether a person’s impairment substantially limits a major life activity:
- a) The nature and severity of the impairment
 - b) How long the impairment will last or is expected to last
 - c) The permanent or long-term impact or expected impact

In your professional judgment, is the individual’s impairment *substantial*? Yes No

If yes, explain how the above factors individually or in combination substantially limit the individual in the performance of one or more major life activities.

6. a) If you believe the individual to have a disability that substantially limits the individual’s ability to perform one or more major life functions, in your professional opinion, *can the individual perform the essential functions of the job* (based on the job description), with or without an accommodation, and without direct threat to their own health and safety and/or the health and safety of others in the workplace?

a. Yes No

b. *Is an accommodation required* to enable the individual to perform the essential functions of the job as described?

Yes No

c) If accommodation is required, can you suggest or *recommend one or more possible reasonable accommodations* that would specifically and directly address/ameliorate the substantial limitation and enable the individual to successfully perform the essential functions of the job?

Yes No

If yes, please suggest reasonable accommodation(s), and describe how such accommodation would enable the individual to successfully perform the essential functions of the job:

7. a) In your professional judgment, can the individual's medical condition be successfully ameliorated with treatment (e.g., medication, diet, physical therapy, surgical treatment)?

Yes No

b) *If yes to 7a*, is the individual compliant with your recommended course of treatment?

Yes No

If no, please explain in detail. _____

8. a) Regular attendance is an essential function of virtually all jobs, and an individual who cannot attend work regularly therefore may not qualify as "able to perform the essential functions of the position." In your professional judgment, does this medical condition create impairment that might ordinarily cause the individual to be unable to report to work in any substantive way?

Yes No

b) *If yes*, please describe. _____

9. Please provide any further information you feel would be useful to Pinellas County Schools in evaluating the individual's medical condition.

HEALTH CARE PROVIDER SIGNATURE
(Do not use signature stamp or designee signature)

DATE