# MEDICAL CERTIFICATION FORM

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|---|---|
| Employee Name: | Date: |
| Unit: | |
| Job Title: | |
| Telephone Number: | SS# |

**The following information is needed to assess the employee's request under the Americans with Disabilities Act.**

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|---|---|
| Type of Prognosis: (Please explain in detail) | |
| Is this Condition: _____Temporary _____Permanent | |
| Date the Condition Began: | Date of Return to Work: |
| Does this condition allow the employee to perform the Essential Functions of his job? ____ YES ____ NO | |
| If not, please describe what type of accommodation is needed for which essential function. | |
| Other Comments: | |

| | |
|---|---|
| Employee's Signature: | Date: |
| Supervisor's Signature: | Date: |
| Health Care Provider's Signature: | Date: |

**Youth Services**
**Central Office ADA Coordinator**
**P. O. Box 66458**
**Baton Rouge, LA 70896**