Americans with Disabilities Act (ADA)
Health Care Provider Certification

Health Care Provider:

Your patient, ______________________________________________ is employed with Detroit Public Schools (DPS) as a ______________________________________ and has requested accommodations under the Americans with Disabilities Act (ADA). If an employee has a covered disability and can perform his or her essential duties with or without accommodations, DPS is required to provide reasonable accommodations. To determine eligibility, please provide the following information but do not include genetic history:

1. Diagnosis:
________________________________________________________________________________________________
________________________________________________________________________________________________

2. Permanent disability: Yes [       ] No [       ] If no, how long ________________________?

3. Describe impairment(s) and major life activities affected: Examples: Can lift no more than 10 lbs/hr; can only climb 10 steps/day; must avoid bending, stooping.
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

4. Please be specific in what accommodations employee needs to perform his or her essential duties: Examples: Requires a reader; enlarged print; first floor only; must avoid sharp objects.
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Health Care Provider’s Signature_______________________________________________ Date ________________________

Specialty_______________________________________________________________________________________________
Address:  ________________________________________________________________________
Phone:  ___________________________________ Fax:  _________________________________

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