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 __________________________________________

Specialty __________________________________________

Address: __________________________________________________________________________

Phone: __________________________ Fax: __________________________

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