Disability Accommodation Certification

Requestor Name: _____ Job Title: _____
(Employees of Towson University Only)

Release of Information Agreement:

I, _____, authorize _____ to share this information with
(Requestor name) (Medical Provider)
Towson University. In addition, I understand that Towson University may contact the medical provider for further information or clarification.

Requestor Signature: _____ Date: _____

NOTE: This form must be completed in full by a health care provider. Forms filled out by the requestor will not be accepted.

Please complete the form below and attach any appropriate supplemental documentation.

Medical Provider Name/Title: _____

Address: _____

Phone Number: _____ License or Certification Number_____

Check all relevant functions which are limited and explain how each limitation will specifically affect your patient in their role at or as a visitor to Towson University.

FUNCTIONAL LIMITATIONS	**COMMENTS**
Breathing	
Concentrating	
Driving	
Hearing	
Interacting with Others	
Learning	
Lifting	
Overhead Work	
Performing Manual Tasks	
Seeing	
Sitting	
Speaking	
Standing	
Walking	
Other(s)	

- How does the individual's limitation(s) interfere with their ability to perform the job function(s) or access a benefit of employment? (Employees and Applicants Only)

- What relevant accommodations do you recommend and why?

If your accommodation recommendation include alterations to the work schedule, please include the recommended alterations:

Recommended length of work day: _____ (hours)

Recommended number of work days/hours a week: _____

Recommended number of breaks: _____ Recommended duration of each break: _____

Recommended work schedule: _____

I certify I have treated the above individual for a medical condition which:

_____ **is a disability under the ADA**

_____ **is not a disability under the ADA, but support is recommended**

_____ **is a short term condition, which requires an accommodation**

Duration of condition/ need for accommodation: _____

- Any other comments:

Medical Provider's Signature: _____ Date: _____