AMERICANS WITH DISABILITIES ACT

PHYSICIAN CERTIFICATION

RE: [name]

Dear Healthcare Provider:

The State of Wyoming requests that you examine [name] (Employee) and provide information regarding: (a) whether the Employee has a physical or mental impairment that substantially limits one or more major life activities, including any functional limitations associated with such impairment(s), (b) whether the Employee's impairment precludes work performance and (c) suggested accommodations that allows the Employee to perform the essential functions of their position.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please respond fully to the questions that follow by [date - 1 calendar month out].

1. CERTIFYING PHYSICIAN NAME AND ADDRESS:

_____

_____

_____

_____

2. Does the Employee have a physical or mental impairment? Yes / No

3. If the Employee suffers from an impairment, does the impairment(s) substantially limit one or more major life activities? Yes / No

4. If the Employee suffers from an impairment(s) that substantially limit(s) one or more major life activities please (check all that apply):

□ Walking	□ Caring for self	□ Normal cell growth
□ Speaking	□ Sitting	□ Digestive functions
□ Breathing	□ Standing	□ Bowel functions
□ Perform manual tasks	□ Lifting	□ Bladder Functions
□ Seeing	□ Sleeping	□ Neurological functions
□ Hearing	□ Working	□ Brain functions
□ Learning	□ Immune System	□ Respiratory functions
□ Circulatory functions	□ Endocrine functions	□ Reproductive functions

□ Other (please specify):	□ None of the above	

3. For any major life activity substantially limited by the Employee's impairment(s), please describe the **nature and severity of the impairment(s) identified above**, and the **expected duration of the impairment(s)** (attach additional sheets if necessary):

4. For any major life activity substantially limited by the Employee's impairment(s), please describe any **expected permanent or long term impact resulting from the impairment(s) identified above** (attach additional sheets if necessary):

5. Please describe the functional limitations of the Employee

6. Please review the attached Job Content Questionnaire (JCQ) and determine what, if any, essential job function(s) or benefits of employment the Employee is having difficulty performing or accessing because of the limitation(s) from the impairment(s). Please discuss the essential functions of the position with the Employee. If you have any questions regarding essential job functions, please contact state Human Resources at [number].

Please list all essential job function(s) that the Employee cannot perform because of the limitation(s) from the impairment(s).

Do you have any suggestions regarding reasonable accommodation(s) by the State of Wyoming that would allow the Employee to perform the essential job function(s) of the position and/or access the benefits of employment (attach additional sheets if necessary):

7. In your opinion, when, will the Employee be able to fully perform the duties listed in the JCQ:

8. Is there an approximate date on which employee can return to full-time or part-time employment:

SIGNATURE:_____**DATE:**_____