Contra Costa Community College District

Medical Verification

Americans with Disabilities Act

To be completed by employee/applicant: [Please print or type]	
Name:	Position:

To be completed by physician/psychiatrist: [Please print or type]

The medical information below is requested by the Contra Costa Community College District so that the District may evaluate a request for reasonable accommodation made by the above employee/applicant under the Americans with Disabilities Act ("ADA") and related state law. The District seeks information to help it determine whether the employee/applicant has a "covered disability" and the nature and extent of the employee/applicant's "functional limitations." Under the ADA, a "disability" is defined as "a physical or mental impairment which limits one or more major life activities." Examples of major life activities include performing manual tasks, walking, seeing, hearing, speaking, learning, and working.

1. Does employee/applicant have a physical or mental impairment which in your opinion limits one or more major life activities? Yes ___ No ___ *(Do not state the medical cause/diagnosis of the impairment.)*

2. What major life activities are limited?

3. What is the probable duration of the impairment?

4. What functional limitations does the impairment place on the employee/applicant's ability to perform the essential job functions of the position or on the applicant's ability to complete the job application and selection process? (See attached job description. Attach additional sheets if necessary.)

5. In your opinion, would the employment of the above person pose a significant risk of harm to himself/herself/or other persons? Yes ___ No ___

6. If your answer to number 5 is "Yes," what is the specific risk involved? The duration of the risk? The nature and severity of the potential harm? The likelihood that the potential harm will occur? The imminence of the potential harm? What reasonable accommodations, if any, could eliminate the risk or reduce it to an acceptable level?

7. Please state any suggestions you may have as to how the employee/applicant can perform the essential job functions of position with accommodations provided by the District or how the applicant can complete the job application and selection process with accommodations? (Attach additional sheets if necessary.)

Physician/Psychiatrist's Name:
(Print)

Business Address/Telephone Number:

Signature:	Date: