St. Lucie PUBLIC SCHOOLS

Each Child, Every Day

9461 Brandywine Lane • Port St. Lucie, FL 34986
772.429.3600 • www.stlucieschools.org

Physician's Documentation of Employee's Functional Abilities and Limitations in Relation to Job Functions

Employee's Name: _____ **Date:** _____

Physician's Name: _____ **Date:** _____

Please answer and return the following questionnaire as soon as possible so that we can effectively evaluate your patient's request for an accommodation. The questionnaire format is a guide and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions if needed to answer more fully. Thank you for your anticipated cooperation. **Please email the form to ada@stlucieschools.org or fax it to 772-429-7501.**

Important Note to Health Care Provider: When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment or appliances, low-vision devices (which include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aides or services; or learned behavioral or adaptive neurological modifications. ***All sections do not have to be filled out; however, the district will only be able to use the information that is provided in determining if a reasonable accommodation is appropriate.**

To be completed by Physician

1. **Does the employee have a physical or mental impairment** **Yes** ☐ **No** ☐

If so, please identify the type of impairment:

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2. Does the employee's impairment substantially limit any major life activities: **Yes** ☐ **No** ☐

If so, which major life activity or activities are limited?

3. For each major life activity that is limited by the impairment, please describe how the employee is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way in which an average person in the general population can perform that activity:

4. What is the duration or expected duration of the employee's impairment?

5. Attached is a job description for the employee's position. Please review the job description and identify whether the employee can perform all job functions. Are there any job functions the employee is unable to performand if so, why not? **Yes** ☐ **No** ☐

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6. Please describe any reasonable accommodations that would allow the employee to be able to perform those job functions:

7. Provide limitations/restrictions for all that apply:

Lifting (Maximum weight): ____ **lbs**

Repetitive Lifting: ____ **lbs**

Carrying: ____ **lbs**

Pushing/Pulling: ____ **lbs**

Able to reach over head **Yes** ☐ **No** ☐

Reach away from body **Yes** ☐ **No** ☐

Walking: ____ **hours per day**

Standing: ____ **hours per day**

Sitting: ____ **hours per day**

Squatting: ____ **hours pers day**

Kneeling: ____ **hours per day**

Crawling: ____ **hours per day**

Climbing: ____ **hours per day**

Repetitive Motion Restrictions:

Reduced in Hours Restrictions: (Please list estimated duration of schedule):

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Recommendations for Medical Leave (Please list estimated duration):

The limitations/restrictions listed are:

Temporary ☐ **Permanent** ☐ **Unknown at this time** ☐

8. Would the employee's performance of any of the job functions listed above result in a direct safety or health threat to this employee or other people (co-workers, students, members of the general public, ect.)? **Yes** ☐ **No** ☐

If so, please describe what job function(s) would pose such a threat, the direct safety or health threat posed, and any reasonable accommodations that would eliminate the direct safety or health threat or reduce it to an acceptable level:

9. Please provide any additional information you believe would assist St. Lucie Public Schools in evaluating the employee's ability to perform the functions of his/her position with or without an accommodation:

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My signature indicates that I have read and understand the employee's job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee's physical capabilities as compared to the essential functions of the job.

Physicians Signature:

Date:

Physician's Name and Address (Please Print):