

Ohio Department of Medicaid  
**ATTENDING PHYSICIAN STATEMENT FOR ADA ACCOMMODATION**

**Instructions for Application**

- \* The attending physician must complete Sections I through VII without expense to the State of Ohio.
- \* Please print legibly or type.
- \* Each section should be completed as thoroughly as possible. Failure to fully complete may result in a denial of the employee's request for accommodation.
- \* Attending physician should retain a copy of all pages of form.
- \* The employee is responsible for returning the entire form to the Bureau of Civil Rights.
- \* Please be certain to review the attached position description and summary of work environment/duties before completing this form.

Employee's Name	
<b>Section I - HISTORY OF ADA CONDITION(S)</b>	
When did you determine this person was disabled?	
Date first consulted you for this condition.	Additional dates of treatment including the most recent visit.
<b>Section II - DIAGNOSIS</b>	
Give complete diagnosis	
Describe fully any complications with this condition	

**Section III - PRESENT CONDITION \*\*PLEASE COMPLETE IN DETAIL\*\***

Subjective symptoms *(describe fully)*

Describe mood and affect, ability to carry out daily activities, follow instructions, judgment, and ability to concentrate. *(Answer if relevant to the claim disability)*

Is there evidence of a thought disorder or impairment in memory? *(Answer if relevant to the claim disability)*

Do you believe that there is a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation? If yes, please explain

**Section IV - PROGNOSIS**

Do you expect marked change in the future?  Yes  No      If yes, When do you think those changes will happen?

**Section V - SUGGESTED ACCOMMODATIONS**

What are the limitations? How would we accommodate them? *(BE SPECIFIC)*

**Section VI - REMARKS**

Additional Remarks

**Section VII - PHYSICIAN SIGNATURE**

Name (Attending Physician) <i>Please print</i>		Specialty	Federal ID #		
Street Address	City	State	Zip Code	Telephone Number	
Date Form Received		Date Signed			
Signature					

## AUTHORIZATION TO RELEASE INFORMATION

**I AUTHORIZE any physician, medical practitioner, hospital, clinic, or other medical or medically-related facility having information available as to diagnosis, treatment, prognosis, and suggested accommodation(s) with respect to any physical or mental condition and/or treatment of me to release and provide such information to my employer, the Ohio Department of Medicaid.**

**Further, I AUTHORIZE the Ohio Department of Medicaid to clarify any information provided by my Health Care Provider.**

**I UNDERSTAND that information obtained with this Authorization will be used by the Ohio Department of Medicaid to determine whether I am covered under the Americans with Disabilities Act (ADA). Any information obtained will not be released to any person or organization except to those persons or organizations performing business or legal services in connection with this claim or as may be lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization.**

**I AGREE that a photocopy of this Authorization will be as valid as the original.**

**I AGREE that this Authorization shall be valid indefinitely.**

Signature

Date

**The Ohio Department of Medicaid requires a medical certification of an individual's disability as defined in the ADA. The Ohio Department of Medicaid reserves the right, at its own expense, to seek a second medical opinion at any time, if deemed necessary.**

***The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title VII from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by 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."***