



Elizabethtown College

Human Resources

Reasonable Accommodation Request – Physician’s Certificate

Please have form completed by physician and forward it to Human Resources.

Patient Name: _____ Examination Date: _____

I certify that the above mentioned patient is permanently / temporarily disabled and may / may not require accommodation.
(circle one) (circle one)

Recommended Accommodation: _____

I examined the above named patient on _____ and certify that the patient has the following permanent / temporary functional limitation(s):
(circle one)

I examined the above named patient on _____ and I am unable to make a determination without further examination. The patient is scheduled for a follow-up exam on _____ with _____.

I examined the above named patient on _____ and I have not found any limitations at this time. This patient may return to regular duty without restrictions on _____.

Physician’s comments: _____

Physician’s Printed Name

Specialty

Physician’s Office

Address, City, State ZIP

Physician’s Signature

Date