GEORGIA DEPARTMENT OF CORRECTIONS
ADA PHYSICIAN'S STATEMENT

Employee's Name	Job Title:	ID:
Physician's Name	Address:	Phone#:

INSTRUCTIONS: Please answer all of the questions below. We need your complete medical opinion, so please feel free to include a more detailed narrative response to all questions, if needed, to answer more thoroughly. When answering these questions, please do not take into consideration corrective effects of mitigating measures, such as, medication, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

( ) Yes	( ) No	Does the employee have a physical or mental impairment? If "yes", type of impairment:
( ) Yes	( ) No	Does the impairment substantially limit any major life activities? If "yes", which major life activity or activities are limited? 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: What is the expected duration of the impairment?

Record Retention: Retain permanently in the employee's local medical file.

( ) Yes	( ) No	Can the employee perform all job functions in the attached description/performance plan? If "no", which job functions cannot be performed, and why not? Please describe any reasonable accommodations that would allow this employee to be able to perform those job functions. If medical leave is one of the possible accommodations listed above, please provide estimated duration for the leave:
( ) Yes	( ) No	Would performing any of those job functions listed result in direct safety or health threat to this employee or others (co-workers, members of the general public, etc…) If "yes", please describe which job function(s) would pose such as threat. Describe the direct safety or health threat posed: Describe any reasonable accommodations that would eliminate the direct safety or health threat, or reduce it to an acceptable level:

Signature of Attending Physician: _____ Date: _____