CITY OF LITTLE ROCK – REASONABLE ACCOMMODATION PHYSICIAN CERTIFICATION FORM

Return completed form to Fax (501) 371-4496, Attention: Labor and Employee Relations Division

EMPLOYEE NAME:

JOB TITLE:

DATE ACCOMMODATION REQUEST RECEIVED:

1) Please review the attached job description. Is the employee able to perform the essential job functions of this position without reasonable accommodation?

Yes No (Please Circle One) - If Yes, no other questions will need to be completed. Please just sign the form and return to the fax number at the top of the page.

2) Does the employee have a physical or mental disability that will interfere with performing one or more of the essential functions of this position?

Yes No (Please Circle One) - If Yes, please describe how the physical or mental disability will interfere with the employee's ability to perform the essential job functions.

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3) What reasonable accommodation(s) to the work requirements or position responsibilities would enable the employee to perform the essential functions of that position?

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4) How long will the employee need the reasonable accommodation? If unable to provide a date, when will he or she be medically reevaluated?

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Please attach any additional documentation, comments, or suggestions.

Physician Name (Printed)	Date
Physician Signature	Telephone Number

Revised 06-21-17