PANDORA

Accommodation Medical Certification Form

The below employee has requested a workplace accommodation, to enable the employee to perform the essential functions of their position, either because of a disability as either defined under the Americans with Disabilities Act (ADA), as amended, or state law, or because the employee is pregnant and seeks an accommodation under the applicable state pregnancy accommodation law. The information requested on this form will assist us in making a determination regarding the employee's request. The information will be treated confidentially and shared only with those who have a need to know.

INSTRUCTIONS: The following form must be completed in detail and signed by the employee's attending medical provider. Please attach additional pages or records as needed. **Do not provide information not related to the employee's ability to perform their job duties. Example: Do not identify an impairment if it does not have an impact on employee's ability to perform their job duties**.

IMPORTANT NOTICE REGARDING GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of potential employees or their family members. In order to comply with this law, Pandora Group is 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.

Section 1: Associate Information – After completing this section and having signed **Section 4**, please have your physician proceed to **Sections 2 & 3**.

Associate Last Name, First Name: _____

Associate Phone Number: _____

Associate Personal Email Address: _____

Associate Pandora ID #: _____

1. Please confirm you have examined the employee and are familiar with the employee's medical history.

_____Yes _____No

Is this medical condition work related
Yes ☐ No ☐

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Section 2: Return to Work information. This section must be completed by the **associate's physician**, in addition, proceed to **Section 3** if option **B** is selected.

Does the employee have a physical or mental impairment(s)?

_____Yes _____No

If yes, please list impairment(s). (**Do not provide medical diagnosis without patient consent in CA, CT, ME, or RI**).

_____

_____

_____

Note: Whether an impairment limits the ability of an individual to perform a major life activity is determined:
- As compared to most people in the general population; and
- Does not need to prevent, or significantly or severely restrict, the individual from performing a major life activity – the impairment only needs to "substantially limit" the potential employee's ability to perform the major life activity.

If yes, which major life activity(s) are affected?

Check all major life activities that both (a) are affected by the employee's impairment(s) and (b) restrict or limit the employee's ability to perform the employee's job duties.

Major Life Activities – General Life Activities:

☐ Bending	☐ Learning	☐ Sleeping
☐ Breathing	☐ Lifting	☐ Speaking
☐ Caring for self	☐ Performing manual tasks	☐ Standing
☐ Concentrating	☐ Reaching	☐ Thinking
☐ Eating	☐ Reading	☐ Walking
☐ Hearing	☐ Seeing	☐ Working
☐ Interacting with others	☐ Sitting	☐ Other (s) (Describe)

_____

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Major Life Activities – Operation of Major Bodily Functions:

☐ Bladder	☐ Genitourinary	☐ Operation of an organ
☐ Bowels	☐ Hemic	☐ Reproductive
☐ Brain	☐ Immune	☐ Respiratory
☐ Cardiovascular	☐ Lymphatic	☐ Sensory organs and skin
☐ Circulatory	☐ Musculoskeletal	☐ Other(s) (Describe)
☐ Digestive	☐ Neurological	_____
☐ Endocrine	☐ Normal cell growth	

2A. ☐ **The associate is able to return to full duty with no workplace accommodations on** _____.
DOCTOR: Section 3C should be blank if this option is marked

2B. ☐ **The associate will require workplace accommodations (All three dates and section 3C are REQUIRED):**

Accommodation Start Date: _____

Accommodation End Date: _____

Anticipated Return to Work: _____

DOCTOR: Complete section 3C if accommodations are needed

Section 3: Accommodation information – The associate's physician must complete this section. Once completed return to the associate to proceed with **Section 4**.

3A. The approximate duration of this medical condition:

Date the medical condition started: _____

Date the medical condition should end: _____

3B. Is the associate unable to perform work of any kind? _____

3C. If the associate is unable to perform any one or more of their essential job functions, please define these limitations:

The limitations below are:

Permanent _____

Temporary _____ (will conclude as per the date in section 2B above)

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3C. Continued – Accommodation's listed below: (will conclude as per the date in section 2B above)

No lifting over _____ lbs.	_____ No Driving _____ No Bending _____ No Reaching	Limited to driving _____miles per day (round trip) -- Only ____ miles per day, continuously (one way) -- Only ____ miles per day with breaks (one way) : for every _____ miles, a _____ minute break.
No standing over _____ hours -- Only _____ hours standing per day continuously or --for every _____ hours, a _____ minute break.		
Maximum of _____ hours of work per day. -- Only _____ hours **working/standing** per day with breaks: for every _____hours, a _____ minute break.		

Other restrictions: _____

_____

D. Additional comments if any:

_____

_____

Print Physician's Name: _____ **Physician Phone #:** _____

Physician Fax #: _____

Physician Signature: _____ **Date:** _____

Section 4: Consent to release. Should be completed by the associate prior to returning this form.

I authorize my healthcare provider to release any information related to my medical condition to return to work. I understand that I may revoke this consent at any time by providing notice in writing to the above-named healthcare provider and that their consent will automatically expire in one (1) year following date of signature without any express revocation. I further understand that a photocopy or facsimile of this authorization has the same enforceability as an original.

Associate Signature: _____ Date: _____