NAFTA Health Care Provider Certification Form

NAFTA HEALTH CARE PROVIDER CERTIFICATION FORM

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Name of Candidate seeking NAFTA Certification Last 4 digits of Social Security No.

The above-referenced individual has identified you as the health care provider who is treating the medical condition for which he/she is seeking reasonable accommodation. Attached is the candidate's signed HIPAA Consent Form. Please complete this certification form and return it in the envelope provided. Please write legibly; if clarification is needed, you will be contacted by a personnel representative. Thank you for your assistance.

Date of your last examination of this individual: _____

A. Major Life Activities

Does this person have a medical condition, that makes one or more of his/hermajor life activity/activities difficult to perform? Yes_____No _____

If yes, the major life activity/activities affected is/are:

_____

B. Duration of Medical Condition

Is this medical condition temporary? Yes_____No _____

If yes, please state the expected duration of this condition:

_____

C. Reasonable Accommodation Request

Please specify what type of accommodation is recommended for this patient as it pertains to an online examination or traditional paper and pencil examination setting:

_____

_____

D. Does the candidate's medical condition necessitate the proposed accommodation? Yes_____No _____

Please explain:

_____

I, the undersigned health care provider, certify that the information I have provided regarding the above- referenced individual is complete and accurate to the best of my knowledge. I understand that my cooperation is necessary to provide accurate determination regarding my patient's reasonable accommodation request.

_____ _____

Health Care Provider's Signature *Date* *Provider's Name Printed*

_____ _____

Provider's Phone number *License No.*