CTDOL EMPLOYEE
RELEASE OF ADA REASONABLE ACCOMMODATION
VERIFICATION FORM

For Current CTDOL Employees Only

The employee's treating health care provider must complete this form to verify the employee is no longer in need of a workplace reasonable accommodation under the Americans with Disabilities Act (ADA).

The employee must provide this completed and signed verification form certification to the CTDOL Office of Diversity and Equity Programs (ODEP) via e-mail at DOL.ODEP@ct.gov before reporting to their department or unit.

Please Print Legibly

Employee's Name:	Employee's ID Number:
Employee's Job Title:	Department/Unit:
Employee's Immediate Supervisor's Name:	Employee's Unit Director's Name :

I have examined _____ and certify that
(print employee's name)
they are no longer in need of their workplace ADA reasonable accommodation.

Date the employee is no longer in need of their workplace ADA reasonable accommodation is on:

Will the employee have any restriction when they return to work? ____ NO ____ YES

If YES, please indicate how long the restriction(s) will last?

If YES, please describe the restrictions (If additional space is needed, please attach a separate sheet):

Name of Physician or Practitioner (please type or print):	Physician or Practitioner License Number:
Name of Office/Practice:	Address:
Phone Number:	Fax Number:
E-mail Address:	Office Hours:
Signed (Physician or Practitioner):	Date: