INDIANA HARBOR BELT RAILROAD COMPANY
2721 – 161ST STREET, HAMMOND, IN 46323-1099

Accommodation Medical Certification

Employee Name & IHB ID#: _____

Job Title & Department: _____

Work Schedule: _____

Please complete and return this form
to Human Resources by _____

PART 1: TO BE COMPLETED BY EMPLOYEE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I have requested an accommodation from Indiana Harbor Belt Railroad Company (the "Company"). I hereby authorize the Company's Human Resources personnel to communicate directly with the health care professional who completes this form in order to obtain clarification of issues relating to the functional limitation(s) for which I am seeking an accommodation. This authorization will automatically expire one year following the date I sign it.

Employee's Signature:_____ Date: _____

PART 2: TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Dear Health Care Professional:

A request for accommodation has been made by the employee referenced above. In order to assist with the interactive process, we are requesting that you provide feedback to the following questions based on your medical expertise.

Please review the attached job description, answer the following questions, and return the completed form directly to the Manager HR/LR, via fax at 219-989-4967 or contact us at 219-989-4850 for an email address.

I have reviewed the job description and essential job functions/for this position and certify that the employee referenced above:

_____ Is medically able to perform all essential functions of the position.

_____ Is medically unable to perform all essential functions of the position.

[PLEASE CONTINUE TO NEXT PAGE]

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If the employee is unable to perform all of the essential functions of the position, please complete the following. Attach additional sheets if necessary.

Identify the job function(s) the employee is unable to perform: _____

_____

Identify the medical condition and functional limitation(s) that render the employee unable to perform such functions: _____

_____

State the expected duration of the medical condition: _____

_____

Are there any accommodations that would enable the employee to perform all essential functions of the position? If so, please describe the accommodation(s) and explain why the recommended accommodation(s) is/are needed: _____

_____

_____

Any additional comments or suggestions:

_____

_____

_____

[PLEASE CONTINUE TO NEXT PAGE]

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Accommodation Medical Certification

Print Name: _____ Date:_____

Type of Practice/ Medical Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____Fax: _____ Email: _____

Signature of medical professional completing form:

_____

Again, please return this completed form directly to the Manager of HR/LR.
You may fax to 219-989-4967 or contact us for an email address.
If you have any questions, please contact us at 219-989-4850.