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

Accommodation Medical Certification

Employee Name: _____ IHB ID# _____

Department: _____ Job Title: _____

Work Schedule: _____

Email: _____ Phone # _____

PART 1: TO BE COMPLETED BY EMPLOYEE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I have requested an accommodation from the 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 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:

An accommodation request has been made by the employee referenced above. In order to assist with the interactive process, we are requesting that you provide feedback on 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 email at HR@ihbrr.com.
Please call 219-989-4923 with any questions.

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.

_____ No functional job description was provided.

[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.

1. Please identify the job function(s) the employee is unable to perform: _____

_____

2. Please identify the medical condition and functional limitation(s) that render the employee unable to perform such functions: _____

_____

_____

3. Please explain how the condition prevents the employee from performing the essential job function(s) as listed above: _____

_____

_____

4. State the expected duration of the medical condition: _____

5. Are there any accommodations or modifications that would enable the employee to perform all essential functions of the position? YES _____ NO _____

   If yes, please describe the accommodation/modification and explain why it is needed and how it will allow the employee to perform the essential function(s) of their job:

_____

_____

_____

_____

[PLEASE CONTINUE TO NEXT PAGE]

6. Please state the dates/length of time this accommodation or modification is needed:

_____

Please provide any additional information or suggestions you feel may aid in the determination of the employee's request:

_____

_____

_____

Doctor's Name: _____

Type of Practice/ Medical Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Signature of medical professional completing form:

_____ Date: _____

Please return this completed form directly to the Manager of HR/LR.
You may fax it to 219-989-4967 or email it to HR@ihbrr.com.
If you have any questions, please contact us at 219-989-4923.