HEALTH CARE PROVIDER CERTIFICATION (CONFIDENTIAL)

To: **Physician or Certified Medical Provider**

From: **CarMax ADA Administrator**

Date: _____

Subject: **Request for Medical Information to Assist with Review of a Request for an Accommodation for** _____ **Date of Birth:** _____

Associate's Name

CarMax is reviewing a request for an accommodation to assist the associate listed above in performing the essential functions of a job or provide access to the work environment and/or access to a benefit/privilege of employment. The information requested below is confidential, the request for medical information has been authorized by the associate (pursuant to the enclosed Associate Certification), and the information obtained will be used only to address the requested accommodation.

If you have any questions regarding this form please contact the Job Accommodations Team at 888-910-1293.

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 an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any request for medical information, such as in the Healthcare Certification response from a physician. "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.

Please answer all questions and sign the certification

Then send completed form to Attention: CarMax Job Accommodations Team via fax or email

Fax: 866-863-8146

Email: ADA_Committee@carmax.com

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1. Relevant medical history for accommodation need(s).

Have you examined and/or diagnosed the associate?		If so, when?	
What is the impairment for which the patient is seeking an accommodation?			
What limitations are caused by the above listed impairment?			
Please describe how the above impairment limits patient's ability to perform job:			

2. Does the impairment involve physical restrictions?

☐ No

☐ Yes
- **Please provide details in the table below**
- **Expected duration of below physical restrictions (check 1):**
  - ☐ Temporary
  - ☐ Permanent
- **Restrictions Start Date** _____ **Restrictions End Date** _____

Activity	Maximum hours per day**	Activity	Maximum hours per day**
☐ Repetitive use of hands		☐ Fine finger motion	
☐ Sitting		☐ Grasping	
☐ Standing		☐ Walking	
☐ Squatting/Kneeling		☐ Reaching	
☐ Bending/Stooping		☐ Pushing/Pulling	
☐ Lifting (indicate max pounds and max time per day)			
☐ Other (provide details):			

****Maximum hours per day is required if a physical restriction is indicated to process the associate's request for accommodation.**

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3. Requested Accommodations:

Requested Accommodation	Specific information about the Accommodation
☐ Purchase of an item or service: Furniture-Seating	☐ Lumbar Support ☐ No Arms ☐ High back ☐ Generous fit chair (for large and/or tall) ☐ Mid-back ☐ Height Adjustable Work Surface
	☐ Other (please specify):
☐ Purchase of an item or service: Equipment	☐ Ergonomic Mouse ☐ Lumbar Support Pillow ☐ Headset ☐ Ergonomic Keyboard
	☐ Other (please specify):
☐ Work schedule modification	Examples: daylight hours only, end shift by 5:00pm, start shift after 11:00am, off Tuesdays,
☐ Other (policy exception, modification of worksite or environment, etc.)	

What is the expected duration of the above accommodation need(s) (specify amount of time, ex. 3 weeks, 2 months)?

_____weeks _____ months _____ years _____ permanent

4. List additional information pertinent to the associate's request for an accommodation.

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5. Leave and/or additional breaks as an Accommodation*:

**__Medical Provider Please Note__: CarMax reviews associate's role in conjunction with physical impairment and accommodation needs to allow him/her to return to work and as such leave as an accommodation is utilized if the associate cannot be accommodated in role.*

<table>
<tr><td>☐ Continuous Leave</td><td colspan="3">Leave Start Date: _____ Leave End Date: _____</td></tr>
<tr><td rowspan="2">☐ Intermittent Leave (Flare-ups)</td><td>Frequency:</td><td colspan="2">_____ times per (☐day/☐week/☐month) and are likely to last
_____ (☐hours/☐days) per episode.</td></tr>
<tr><td>Duration of Intermittent Leave Needed:</td><td colspan="2">Specify amount of time (ex. 3 weeks, 2 months)
____weeks ____months ____ years _____ permanent</td></tr>
<tr><td rowspan="2">☐ Intermittent Leave (Appointments)</td><td>Frequency:</td><td colspan="2">_____ times per (☐day/☐week/☐month)</td></tr>
<tr><td>Duration of Intermittent Leave Needed:</td><td colspan="2">Specify amount of time (ex. 3 weeks, 2 months)
____weeks ____months ____ years _____ permanent</td></tr>
<tr><td rowspan="4">☐ Additional Break Time</td><td rowspan="4">Details:</td><td># Per Day:</td><td>Examples: 1, 2</td></tr>
<tr><td>Duration of Break:</td><td>Examples: 5 minutes, 15 minutes, 30 minutes</td></tr>
<tr><td>Duration of Break Need:</td><td>Specify amount of time (ex. 3 weeks, 2 months)
____weeks ____months ____ years _____ permanent</td></tr>
<tr><td colspan="2">☐ Unscheduled</td><td>☐ Scheduled
Examples: Every 4 hours, at 10:00am & 2:00pm</td></tr>
</table>

MEDICAL PROVIDER CERTIFICATION

Signature of Medical Provider_____**Date:** _____

Printed Name of Medical Provider _____

Type of Practice/Medical Specialty _____

Office Number:_____ **Fax Number:** _____