NEW JERSEY DEPARTMENT OF HUMAN SERVICES
ESSENTIAL FUNCTIONS WORKSHEET

ADA Coordinator: The development of this form is intended to describe the essential job functions of this position. Please provide a brief job description and list the essential job functions. The completed form will be reviewed by the medical provider to determine whether the employee is able to perform the essential job functions as described, and return to his/her position or alternate position. Please ensure that all information provided is current and accurate as this is an important document utilized to obtain information on how an employee's medical condition could/may impact his/her ability to perform the essential job functions with or without a reasonable accommodation.

Medical Provider: Your assistance is requested to identify what job functions the employee can or cannot do as currently performed. Following your review of the essential job functions and based on the employee's medical condition, please provide your responses as indicated. Your prompt reply is necessary so that DHS can determine the return to work status of this employee. Instructions:

For questions or clarifications, please contact_____, ADA Coordinator at _____

Name: _____

Job Title: _____ Division: _____

Location: _____ Shift: _____

Person Completing Form (Name and Title): _____

Date: _____

Instructions:

1. Functions/Work Duties – describe the work required of this position. This description should be clear enough for a person unfamiliar with the work to understand exactly what is done.

2. Percent of time – percent of time necessary to complete the assigned function, note percentage number.

3. Essential function – identification of function as essential, note yes/no.

4. Basis – reason function determined to be essential, note code letter or letter(s) as applicable.

    a. Job exists to complete this task
    b. Only position that performs this specialized task in unit/section
    c. Only position that performs this specialized task in job title
    d. Previous incumbent did this task
    e. Task competed daily or weekly
    f. Significant consequences if task not performed

5. If multiple pages are necessary, check form where indicated on Essential Functions Worksheet, "continued on attached page".

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ESSENTIONAL FUNCTIONS WORKSHEET

FUNCTIONS/WORK DUTIES	PERCENT OF TIME	ESSENTIONAL FUNCTION (Yes or No)	BASIS	CAN PERFORM (Yes)	CANNOT PERFORM (No)

( ) Check here if continued on attached page

Medical Provider comments:
(If "NO" is checked under "Cannot Perform," please specify the employee's functional abilities/inabilities in relation to the essential functions and time requirement. Suggestions/recommendations (if known) for reasonable accommodation which will enable the employee to perform that activity is appreciated.)

IMPORTANT: PLEASE INDICATE BELOW IF WORK RESTRICTIONS/LIMITATIONS ARE PERMANENT OR TEMPORARY.

____ Please check here if restrictions are permanent.

____ Please check here if restrictions are temporary. (Specify Dates) From: _____ through _____

_____ _____
Medical Provider Name **Signature and Date**