REQUEST FOR REASONABLE ACCOMMODATION IN EMPLOYMENT

MEDICAL PROVIDER CERTIFICATION

Today's Date:	Employee ID #:
Employee Name:	Work Phone:
Job Title:	Department:
Supervisor Name:	Supervisor Phone:

To the medical practitioner: Your assistance is appreciated in providing information to assist in determining reasonable accommodation in employment for the above-named individual, who has identified himself/herself as your patient. This employee is requesting that the San Joaquin County ____________ Department consider a workplace accommodation(s) to facilitate his/her performance of the essential functions of her job as __________________.

The Department needs this information to assist in determining whether the extent of the employee/patient's "functional limitations" require reasonable accommodations to allow him/her to perform the essential functions of the position as __________________.

The Department is not seeking information regarding diagnosis, prognosis or other protected information; but rather, functional capacities, limitations and/or work restrictions. In accordance with the Genetic Information Non Discrimination Act, the Agency also specifically directs you not to provide genetic information, including family medical history, in your response to the following questions.

All information relating to an accommodation request, including medical documentation, shall be maintained in separate files and shall be treated as confidential medical records with access limited to supervisors/managers who need to be informed regarding necessary work restrictions and accommodations, first aid personnel (when appropriate), and review by government officials investigating compliance with the California Fair Employment & Housing Act (FEHA), the Family & Medical Leave Act (FMLA) and California Family Rights Act (CFRA) or other pertinent law. Please contact the representative listed below if you have any questions. Attach additional pages if necessary.

Please note: "Disability" is defined under the California Fair Employment & Housing Act (FEHA) as "a limitation of a major life activity or a limitation that makes achievement of a major life activity more difficult to achieve." This may be a physical or mental illness or medical condition that limits a major life activity or makes achievement more difficult. [California Government Code § 12926]. Further applicable definitions:

Physical Disability is defined as: Having any physiological disease, disorder, condition, cosmetic disfigurement, or anatomical loss that does both of the following:

(A) Affects one or more of the following body systems: neurological, immunological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin and endocrine.

(B) "Limits" a major life activity

Mental Disability is defined as: (1) Having any mental or psychological disorder or condition, such as mental retardation, organic brain syndrome, emotional or mental illness, or specific learning disabilities, that may limit a major life activity. (2) Any other mental or psychological disorder or condition that requires special education or related services.

Major life activities include without limitation the following: working, seeing, sleeping, remaining alert, learning, hearing , breathing , thinking, concentrating, reading, interacting with others, communicating, performing manual tasks, performing cognitive tasks, walking, lifting, reaching, caring for oneself.

"Limits" includes making achievement of major life activities difficult.

I. Covered Disability

1. Applying these definitions, does this patient have a **physical or mental limitation or a medical condition** that limits the performance one or more major life activities?

   ____Yes ____No

2. Describe the major life activities, if applicable, which this patient's limitation or condition prevents, restricts or makes more difficult.
   - ______________________________
   - ______________________________
   - ______________________________
   - ______________________________

II. Functional Capacities and/or Limitations Section

2. Based on your review of the employee/patient's job duties, please list the functions that the employee will be limited or restricted in performing. (i.e. Stocking shelves)
    - ____
    - ____
    - ____
    - ____

3. Based on your response to Question 1, please specify the physical restrictions that are affecting the performance of the duties listed above. (i.e. reaching overhead is limited due to pain)
    - ____
    - ____
    - ____
    - ____

4. Based on your review of the employee's job duties, please list the functions that the employee is capable of performing without limitations and/or restrictions.
    - ____
    - ____
    - ____
    - ____

3. Please specify whether the period of disability/restrictions/limitations are either:
    - ☐ Temporary: ______________ ______________
      (start date) (end date)
    - ☐ Permanent

III. Leave of Absence

4. If you recommend a leave of absence as an accommodation, will the leave enable Employee to return to work and perform the essential functions of the job?
   ___Yes ___No ___Cannot ascertain at this time

5. Please state how much time off you believe will be medically necessary and effective to enable employee to perform his/her job functions, by providing a reasonably definite return to work date below.
   Date: ________________________

6. Are you reasonably certain Employee will be able to work as of that date?
   ___Yes ___No. If no, why not?

7. Please identify any alternatives to time off from work that would enable Employee to perform employee's job functions now or sooner than the additional time off you have recommended.

8. Please describe what other accommodations may be necessary at the conclusion of the extended leave to enable Employee to perform Employee's job functions.

9. Please feel free to include any other input you feel may be helpful during the reasonable accommodation analysis.

Please sign, date and return this form to the employee:

Physician Name (Print):	**Date:**
Physician Signature:	**Facility Name:**

SAN JOAQUIN COUNTY
REQUEST FOR REASONABLE ACCOMMODATION IN EMPLOYMENT
EMPLOYEE FORM

What is the purpose of a reasonable accommodation?

The purpose and goal of a reasonable accommodation is to enable a disabled employee in performing the essential functions of his/her job to the same standard that is expected of his/her peers.

What are essential functions?

Essential Functions are the job duties that are so fundamental to the position that the individual holds, or desires to hold, that he or she cannot do the job without performing these duties. A function is "essential" if, among other things, the position exists specifically to perform that function. (This does not include marginal functions that are not essential to the position.)

Note to employee:

Your Department needs this information to assist in determining, what if any reasonable accommodations need consideration to assist you in performing the essential functions of your job.

The Department is not seeking information regarding your diagnosis, prognosis, genetic information or other protected information; but rather, work specific functional capacities and/or work restrictions.

All information relating to an accommodation request, including medical documentation, shall be maintained in separate files and shall be treated as confidential medical records with access limited to supervisors/managers who need to be informed regarding necessary work restrictions and accommodations, first aid personnel (when appropriate), and review by government officials investigating compliance with the California Fair Employment & Housing Act (FEHA), the Family & Medical Leave Act (FMLA) and California Family Rights Act (CFRA) or other pertinent law.

Please also be aware that at times there is a need to request additional information and/or clarification of information. As such, a limited medical release authorization has been embedded into this form to allow a County representative to make direct contact with your medical provider. However, signing the form is voluntary in nature. If you opt not to sign the form, the request for information will simply be directed to you.

Your active participation throughout the interactive process is important. Representatives from both your department and Human Resources are looking forward to working with you through the process.

Please be advised that although, Human Resources staff serves as facilitator(s) during interactive process meetings, final determinations are made by your department.

Should you have any general questions or concerns, regarding the interactive process and reasonable accommodations, please contact the Human Resources at (209) 468-3370.

San Joaquin County

Employee Questionnaire Form

Complete the questions below to the best of your ability. If you cannot provide exact information, do your best with approximates. Feel free to attach extra paper if needed.

Today's Date:	Employee ID #:
Employee Name:	Work Phone:
Job Title:	Department:
Supervisor Name:	Supervisor Phone:

1. Based on your understanding and experience of your current position's essential functions, what duties are you limited in performing due to your medical condition?
   - ____
   - ____
   - ____
   - ____

2. Based on your understanding and experience of your current position's essential functions, what duties are you capable of performing without restrictions?
   - ____
   - ____
   - ____
   - ____

3. Do you have any work restriction(s) ordered by your doctor?
   - _____Yes
     - i. Please provide a copy to your supervisor or manager
     - ii. Please keep a copy for your records
   - _____No

4. Based on your understanding and experience of your current position, please list reasonable accommodations that you feel would be helpful in enabling you to perform the essential functions of your job.
   - ____
   - ____
   - ____
   - ____

SAN JOAQUIN COUNTY
LIMITED MEDICAL RELEASE OF INFORMATION
EMPLOYEE'S AUTHORIZATION

As part of my request for reasonable accommodation, I authorize my health care provider to disclose pertinent information relative to my physical/mental functional capacities as well as any work related medical restrictions/limitations as a result of my medical condition.

I understand that signing this form is voluntary and that if I choose not to provide authorization, it will be incumbent upon me to provide any additional information requested by my department to complete the reasonable accommodation analysis.

I authorize this release to be valid for six (6) months from the date of my signature.

I authorize limited release of my functional limitation and/or functional capacities.

Employee Signature: ____ Date: ______________

Designate the medical provider that you are authorizing to release your information:

Physician Name: ____

Mailing address: ____

____

Medical Provider Phone: ___________________
Medical Provide Fax: ______________________

I am declining to provide a limited medical release authorization at this time.

____   _____________________
Signature   Date

Updated 05.31.19