



**EMPLOYEE – Reasonable Accommodation Request**

Employee Name:	Employee Number:	Today's Date:
Job Title:	Email Address:	
Department:	Work Phone:	
Supervisor Name:	Supervisor Phone or Email:	
Current Work Schedule (Days and Hours):		

*Under state and federal law, employees who have a disability may be entitled to reasonable accommodation if they need such accommodation to perform their job functions. If you require reasonable accommodation to perform your job functions due to disability, please **complete this request form and have your Health Care Provider ALSO complete the attached Medical Certification Form**. Return both forms by mail or fax to the address/fax listed at the bottom of the page. A form of accommodation may include a request for extended leave beyond state and federal FMLA/CFRA and Memorandum of Understanding provisions.*

**1. Please describe any physical, mental, or cognitive impairment(s) that limit your ability to do your job:** *(Under California Law, you are **not** required to disclose your diagnosis.)*

**2. Describe the accommodation(s) you are requesting:** *(Be as specific as possible. If you are requesting a leave of absence, specify the period of leave needed.)*

**3. Describe how the requested accommodations will enable you to perform your job:**

**4. Please provide any other information that might help us to evaluate your request:**

By signing this form, you are giving the County of San Luis Obispo permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act (ADA) and Fair Employment Housing Act (FEHA). This may include the County speaking to appropriate County personnel and/or your health care provider to determine whether and how reasonable accommodation can be made. All information obtained during this process will be maintained and used in accordance with ADA/FEHA confidentiality requirements. As part of this process, you will be required to provide appropriate documentation of your disability, including the impact of the functional limitations on your ability to perform the essential functions of your job. If it is determined that you have a qualifying disability, the County will provide accommodation if it can do so without undue hardship. The accommodation(s) requested on this form may not be the exact accommodation(s) provided, but a comparable substitute. ALL REQUESTS AND MEDICAL CERTIFICATIONS WILL BE KEPT IN A CONFIDENTIAL MEDICAL FILE.

\_\_\_\_\_  
 Signature of Employee

\_\_\_\_\_  
 Date

**RETURN FORM TO: YOUR DEPARTMENT PAYROLL COORDINATOR, OR THE HUMAN RESOURCES OFFICE AT COUNTY GOVERNMENT CENTER, 1055 MONTEREY STREET, SUITE D-250, SAN LUIS OBISPO, CA 93408**



**HEALTH CARE PROVIDER – ADA Certification Form**

*NOTE: The information sought herein pertains only to the condition for which the employee is requesting accommodation under the Americans with Disabilities Act (ADA) and Fair Employment and Housing Act (FEHA).*

To be completed by <b>EMPLOYEE</b>	Employee Name:	Employee Number:	Date of Birth:
	Job Title:	Department:	
	I authorize my health care provider(s): _____		
	to release the following information from my patient file to the County of San Luis Obispo for the purpose of exploring coverage and reasonable accommodations under the ADA and FEHA. _____		
	Signature of Employee	Date	

To be completed by <b>HEALTH CARE PROVIDER</b>	Health Care Provider Name:	License Number:					
	Address:	Specialization/Type of Practice:					
	Phone Number:	Fax Number:					
	<b>INSTRUCTIONS:</b> Attached is a copy of the employee’s job description which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. PLEASE REVIEW THE JOB DESCRIPTION PRIOR TO COMPLETING THIS FORM. (If you did not receive the job description, please contact Human Resources at 805.781.5959 to obtain a copy.) The following questions will help to determine whether the employee has a qualifying disability. A person has a qualifying disability under the ADA/FEHA if the person has a mental or physical impairment that limits one or more major life activities. (Major life activities include working.)						
	1. <b>Does the employee/patient have a physical or mental impairment that limits their ability to perform any of their job functions?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No						
	2. <b>(If Yes) How does the employee’s impairment limit their ability to perform any of the job functions set forth in the attached job description?</b>						
	3. <b>Is the impairment permanent?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No						
	4. <b>If <u>not</u> permanent, how long will the impairment likely last?</b> Ending Date: _____						
	5. <b>Is this a condition which:</b>						
	<table border="0"> <tr> <td>a. Requires periodic visits for treatment by a health care provider?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>b. Continues over an extended period of time?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>c. May cause episodic rather than a continuing period of incapacity?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>		a. Requires periodic visits for treatment by a health care provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Continues over an extended period of time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	c. May cause episodic rather than a continuing period of incapacity?
a. Requires periodic visits for treatment by a health care provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
b. Continues over an extended period of time?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
c. May cause episodic rather than a continuing period of incapacity?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
6. <b>Is the patient taking medications or treatments that would be expected to affect job performance and that would pose a direct threat or safety risk? (SEE ATTACHED JOB DESCRIPTION)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please explain:</b>							

**ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S MEDICAL FILE  
FAX COMPLETED CERTIFICATION TO CONFIDENTIAL FAX: 805-788-2410**



Employee Name: \_\_\_\_\_ Employee Number: \_\_\_\_\_

**HEALTH CARE PROVIDER – ADA Certification Form (Continued)**

To be completed by <b>HEALTH CARE PROVIDER</b>	Physical Activity	Permanent Limitation	Temporary Limitation	If temporary, what is the duration of the limitation? (Please include any comments)
	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	
Standing	<input type="checkbox"/>	<input type="checkbox"/>		
Walking	<input type="checkbox"/>	<input type="checkbox"/>		
Bending Over	<input type="checkbox"/>	<input type="checkbox"/>		
Climbing	<input type="checkbox"/>	<input type="checkbox"/>		
Pushing & Pulling	<input type="checkbox"/>	<input type="checkbox"/>		
Crouching/Stooping	<input type="checkbox"/>	<input type="checkbox"/>		
Reaching Overhead				
· Right	<input type="checkbox"/>	<input type="checkbox"/>		
· Left	<input type="checkbox"/>	<input type="checkbox"/>		
Kneeling				
· Right	<input type="checkbox"/>	<input type="checkbox"/>		
· Left	<input type="checkbox"/>	<input type="checkbox"/>		
Lifting or Carrying				
· 10 lbs or less	<input type="checkbox"/>	<input type="checkbox"/>		
· 11 to 25 lbs	<input type="checkbox"/>	<input type="checkbox"/>		
· 26 to 50 lbs	<input type="checkbox"/>	<input type="checkbox"/>		
· 51 to 75 lbs	<input type="checkbox"/>	<input type="checkbox"/>		
· 76 to 100 lbs	<input type="checkbox"/>	<input type="checkbox"/>		
· Over 100 lbs	<input type="checkbox"/>	<input type="checkbox"/>		
Repetitive Use of Hands				
· Right	<input type="checkbox"/>	<input type="checkbox"/>		
· Left	<input type="checkbox"/>	<input type="checkbox"/>		
Simple/Light Grasping				
· Right	<input type="checkbox"/>	<input type="checkbox"/>		
· Left	<input type="checkbox"/>	<input type="checkbox"/>		
Firm/Strong Grasping				
· Right	<input type="checkbox"/>	<input type="checkbox"/>		
· Left	<input type="checkbox"/>	<input type="checkbox"/>		
Fine Motor				
· Right	<input type="checkbox"/>	<input type="checkbox"/>		
· Left	<input type="checkbox"/>	<input type="checkbox"/>		
Indicate Level of Mental, Emotional, and Sensory Limitation:				
Pace of Work	<input type="checkbox"/> Fast <input type="checkbox"/> Avg <input type="checkbox"/> Below Avg	Hearing	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Manage Multiple Priorities	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Reading	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Intense Customer Interaction	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Analyzing	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Multiple Stimuli	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Verbal Communication	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Frequent Change	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Written Communication	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Short-term Memory	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Vision	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Long-term Memory	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Attention Span	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Reasoning	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Is this condition related to a work related injury that occurred while working for the County of San Luis Obispo? If yes, what is the date of injury (if known): _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

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Employee Name: \_\_\_\_\_ Employee Number: \_\_\_\_\_

**HEALTH CARE PROVIDER – ADA Certification Form (Continued)**

The following question will help to determine whether an accommodation is needed.

**1. What job function(s) listed in the attached job description is the employee having difficulty performing because of their impairment(s)?**

**Comments:**

To be completed by  
**HEALTH CARE PROVIDER**

As the above employee's health care provider, I certify that the employee has a physical or mental impairment that limits their ability to perform their job functions.

\_\_\_\_\_  
 Signature of Health Care Provider

\_\_\_\_\_  
 Date

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