Employee completes

Employee Reasonable Accommodation Request Form

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 a disability, please **complete this request form and have your physician ALSO complete the attached Physician's Medical Certification Form** and return both forms to the address listed at the bottom of the page to Human Resources Department. A form of accommodation may include a request for extended leave beyond state and federal FMLA/CFRA and Memorandum of Understanding provisions.

EMPLOYEE NAME:	**EMPLOYEE ID #:**	**HOME PHONE OR CELL:**
JOB TITLE:	**EMAIL ADDRESS:**	
DEPARTMENT LOCATION:	**WORK PHONE:**	
SUPERVISOR'S NAME:	**SUPERVISOR'S EMAIL:**	
CURRENT WORK SCHEDULE (DAYS AND HOURS):		

PLEASE USE BACK OF SHEET IF YOU NEED MORE ROOM TO ANSWER ANY QUESTIONS LISTED BELOW.

1. Please describe any physical, mental, or cognitive impairment(s) that limits your ability to do your job. (Please note: 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 City of San Bruno permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act (ADA) and Fair Employment and Housing Act (FEHA). This may include the City of San Bruno speaking to appropriate City personnel and/or your health care professional 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, then the City of San Bruno 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_____DATE _____

RETURN FORM TO:

Human Resources
City of San Bruno, 567 El Camino Real, San Bruno, CA 94066
Email: hr@sanbruno.ca.gov

Physician Certification for Reasonable Accommodation

Doctor Completes

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).

EMAIL COMPLETED CERTIFICATION TO HUMAN RESOURCES AT HR@sanbruno.ca.gov

To be completed by **EMPLOYEE**

Employee Name:	**D.O.B:**	**Employee ID#:**
Job Title:	**Department:**	
I authorize my medical provider(s): **to release the following information from my patient file to the City of San Bruno for the purpose of exploring coverage and reasonable accommodations under the ADA and FEHA.**		
Employee Signature:		**Date:**

To Be Completed by the **HEALTHCARE PROVIDER**

INSTRUCTIONS: 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 ATTACHED JOB DESCRIPTION PRIOR TO COMPLETING THIS FORM**. If you did not receive the job description, please contact Human Resources to obtain a copy.

Physician Name/License #:	**Specialization / Type of Practice:**	
Address:	**Fax Number:**	**Phone Number:**

Questions to help determine whether an employee has a qualifying disability. *A person has a qualifying disability under the ADA/FEHA if the person has an impairment that limits one or more major life activities. ("Major life activities" includes working.)*

1. Does the employee/patient have a physical or mental impairment that limits his/her ability to perform any of his/her job functions?	Yes ☐	No ☐
2. (If Yes) How does the employee/patient's impairment limit his/her ability to perform any of the job functions set forth in the attached job description?		
3. Is the impairment permanent?	Yes ☐	No ☐
4. If <u>not</u> permanent, how long will the impairment likely last (ending date)?		
5. Is this a condition which: **A.** requires periodic visits for treatment by a health care provider?	Yes ☐	No ☐
B. continues over an extended period of time?	Yes ☐	No ☐
C. may cause episodic rather than a continuing period of incapacity?	Yes ☐	No ☐
6. 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)	Yes ☐	No ☐
If yes, please explain.		

Employee's Name:_____

Physician Certification for Reasonable Accommodation-Continued

To Be Completed by the **HEALTHCARE PROVIDER**

Questions to help determine whether accommodation is needed.

What job function(s) listed in the attached job description is the employee having difficulty performing because of his/her impairment(s)?

Questions to help determine effective accommodation options.

Do you have any suggestions regarding accommodations that would enable the employee/patient to perform the job duties in the attached job description? If so, what accommodations do you suggest?

Questions regarding a request for a leave of absence as accommodation.
If you believe that the employee requires a leave of absence for accommodation, please specify the estimated date the employee will be able to return to work. If unknown, we still must have the closest estimated date.

When the employee returns will he/she be able to complete the essential functions of the job with or without reasonable accommodation?

If no, please provide long and short-term limitations and accommodations needed and any other comments that would helpful in the determination process.

Comments:

☐ As the above employee's physician, I certify that the employee has a physical or mental impairment that limits the employee's ability to perform his/her job functions.

Physician Signature: **Date:**

City of San Bruno, Human Resources, 567 El Camino Real, San Bruno, CA 94066 Fax: (650) 742-6515

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S MEDICAL FILE

Employees Name: _____ EE ID# _____

Physician Certification for Reasonable Accommodation-Continued

Physical Activity	Temporary Limitation	Permanent Limitation	Duration of Limitation
Sitting			
Standing			
Walking			
Bending Over			
Climbing			
Reaching Overhead (L/R)			
Kneeling (L/R)			
Pushing & Pulling			
Crouching/stooping			
Lifting or Carrying			
• 10 lbs or less			
• 11 to 25 lbs			
• 26 to 50 lbs			
• 51 to 75 lbs			
• 76 to 100 lbs			
• Over 100 lbs			
Repetitive Use of Hands			
• Right Only			
• Left Only			
• Both			
Simple/Light Grasping			
• Right Only			
• Left Only			
• Both			
Firm/Strong Grasping			
• Right Only			
• Left Only			
• Both			
Fine motor, right hand			
Fine motor, left hand			

Indicate Level of Mental, Emotional, and Sensory Limitations

Pace of Work	☐ Fast ☐ Avg ☐ Below Avg	Reasoning	☐Mild ☐ Moderate ☐Severe
Manage Multiple Priorities	☐Mild ☐ Moderate ☐ Severe	Hearing	☐Mild ☐ Moderate ☐Severe
Intense Customer Interaction	☐Mild ☐ Moderate ☐Severe	Reading	☐Mild ☐ Moderate ☐Severe
Multiple Stimuli	☐Mild ☐ Moderate ☐Severe	Analyzing	☐Mild ☐ Moderate ☐Severe
Frequent Change	☐Mild ☐ Moderate ☐Severe	Verbal Communication	☐Mild ☐ Moderate ☐Severe
Short-term Memory	☐Mild ☐ Moderate ☐Severe	Written Communication	☐Mild ☐ Moderate ☐Severe
Long-term Memory	☐Mild ☐ Moderate ☐Severe	Vision	☐Mild ☐ Moderate ☐Severe
Comments Section:		Attention Span	☐Mild ☐ Moderate ☐Severe

Is this condition related to a work-related injury that occurred while working for the City of San Bruno?	Yes ☐	No ☐
If yes, date of injury (if known)		