SAN JOAQUIN COUNTY

Guide to ADA/FEHA Reasonable Accommodation for Employees

DEFINITION of DISABILITY UNDER the AMERICANS with DISABILITIES ACT (ADA) and the CALIFORNIA FAIR EMPLOYMENT and HOUSING ACT (FEHA):

To [have] a disability under the ADA/FEHA, an impairment must limit one or more major life activities. These are activities that an average person can perform with little or no difficulty. Examples include:

- Walking
- Hearing
- Speaking
- Seeing
- Breathing
- Learning
- Performing Manual Tasks
- Caring for Oneself
- Working

PURPOSE

A reasonable accommodation is provided for an eligible employee to enable him/her to perform his/her job's **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.

INSTRUCTIONS - REASONABLE ACCOMMODATION PROCESS

- Employee requests a reasonable accommodation
- "Employee's Request for Reasonable Accommodation" packet is provided to the employee by either supervisor, manager, department personnel office, or Human Resources, Disability Management Unit
- Employee completes and signs the "Employee's Request for Reasonable Accommodation" Form
- Employee's physician must complete and sign the Physician's Questionnaire section of the form
- Employee submits all completed, signed sections of the form to their supervisor, manager, department personnel office, or Human Resources, Disability Management Unit
- Employee will receive a Confirmation of Receipt notice from either a department representative or Human Resources, Disability Management Unit
- Employee's department and Human Resources will coordinate a meeting with the employee to discuss and explore possible reasonable accommodation options

SAN JOAQUIN COUNTY

AMERICANS with DISABILITIES ACT (ADA)
CALIFORNIA FAIR EMPLOYMENT and HOUSING ACT (FEHA)

EMPLOYEE'S REQUEST FOR REASONABLE ACCOMMODATION

TO BE COMPLETED BY EMPLOYEE: (please print clearly)

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

1. Do you have a physical and/or mental impairment? **YES** ☐ **NO** ☐

If YES, name the impairment(s) and describe briefly:

_____

_____

_____

2. Due to the impairment listed in response to Question 1, are you seeking a reasonable accommodation to enable you to perform the essential functions of your position? **YES** ☐ **NO** ☐

3. Does the physical and/or mental impairment limit your ability to perform particular job tasks and duties? **YES** ☐ **NO** ☐

4. Based on your understanding of your current position, what tasks and duties are you unable to accomplish because of your impairment? (List all that apply)

_____

_____

4b. Based on your understanding of your current position, what tasks and duties are your capable of performing? List everything you can do as it relates to your job.

_____

_____

5. Do you currently have any medical work restriction(s) ordered by your doctor?

YES ☐ NO ☐

<u>If YES</u>, list restriction(s) and describe briefly. Please indicate if restriction(s) are permanent or temporary and anticipated duration of the restriction(s).

_____

_____

_____

6. Based on your understanding of your current position, what reasonable accommodation(s) could be made that would enable you to perform the essential functions of your position? Be as specific as possible. (List purchasable items, suggestions for work site modification, specific duties that can be restructured, etc.)

_____

_____

_____

<u>ACKNOWLEDGMENT and AUTHORIZATION</u>

This request for reasonable accommodation will assist me in performing the essential functions of my job.

As part of my request for reasonable accommodation, I authorize my health care provider to disclose to San Joaquin County all information relative to the physical/mental impairment identified on this request form, and any related medical restrictions/limitations. I further authorize San Joaquin County to disclose the relevant medical restrictions/limitations as necessary to provide effective reasonable accommodation.

I understand that failure to provide such authorization may result in the County being unable to provide the requested accommodation.

This release is valid for six (6) months from the date of employee's signature.

Signature: _____ Date: _____

Please print clearly:

Name: _____

Mailing address: _____

_____

Home Phone: _____ Alternate Contact Number: _____

To be completed by Department or HR:

Initial Rec'd Date:	Initially Rec'd By:
Copy Forwarded On:	Copies sent to:

PHYSICIAN QUESTIONNAIRE

Employee Name: _____
Occupation: _____
Department: _____

Physician Name: _____
Address: _____
Phone: _____

INSTRUCTIONS TO HEALTH CARE PROVIDER:

Your patient/our employee, _____, has made a Request for Reasonable Accommodation under the Americans with Disabilities Act (ADA) and California Fair Employment and Housing Act (FEHA). In order to process this request, San Joaquin County needs your assistance with responding to following questions:

Please feel free to attach additional pages if necessary.

Thank you for your immediate attention to this matter.

1. Is _____able to return to work?
   - ☐ Yes, as of the date of this certification
   - ☐ Not at this time. Anticipated release date to return to work: _____

2. Does_____ have a condition limiting a major life function?
   - ☐ No
   - ☐ Yes, please answer the following:
     a. Is the impairment: ☐ Physical ☐ Mental ☐ Both

     b. What is the limiting major life function? Check all that apply:

     ☐ Caring for self ☐ Performing manual tasks

     ☐ Seeing ☐ Hearing ☐ Speaking ☐ Breathing

     ☐ Walking ☐ Standing ☐ Lifting ☐ Reaching ☐ Sitting ☐ Working

     ☐ Learning ☐ Concentrating ☐ Interacting with others

     ☐ Thinking ☐ Sleeping ☐ Other_____

     c. Describe how the impairment limits the employee:_____
     _____
     _____

3. Have you reviewed a job description or job analysis pertinent for this employee's job classification?

☐ Yes
☐ No

4. Based on review of the job description/job analysis are there any job tasks and duties that are limited or restricted?

☐ Yes
☐ No

5. Please specify the job tasks and duties that you feel are being limited by the employee's impairment. Please explain why the job tasks are being affected by the employee's impairment. (i.e. driving, increases back pain): *Please use additional paper if needed*

_____
_____
_____

6. Based on your response to question 5, are there any recommended work restrictions for these tasks and duties? (i.e. no sitting greater than 20 minutes at a time without a break): *Please use additional paper if needed*

_____
_____
_____

6b. What job tasks and duties is the employee capable of performing without any limitations or restrictions? Please list all that apply.

_____
_____
_____

7. Are the work limitations or work restrictions permanent in nature? ☐ Yes ☐ No

8. If the limitations/restrictions are **temporary**, please specify the anticipated disability duration
Start Date:_____ thru End Date:_____

8b. If the limitations/restrictions are temporary in nature, do you anticipate the employee being released to return to work without restrictions? YES ☐, if yes when?_____ NO ☐

9. Are there any recommended accommodations that could assist this employee in performing the essential functions of his/her job? (i.e. allow for micro-stretch breaks): *Please use additional paper if needed*

_____
_____
_____

10. Is the employee currently on medication that would interfere with the employee's ability to safely perform job functions without risk of harm to the employee or others in the workplace?

☐ Yes
☐ No

11. Please comment if there any other pertinent information which may assist us in facilitating the employee's ability to perform the essential functions of their job.

_____
_____
_____
_____
_____

Physician Declaration:

I understand that I am providing the request information to assist the County of San Joaquin in determining whether it can provide an accommodation for my patient, _____. I certify that the information I am providing is true and correct and accurately reflects my medical assessment and opinion concerning _____.

_____

Physician Name (please print clearly) Physician Signature

_____

Date

To be completed by Department or HR:

Initial Rec'd Date:	Initially Rec'd By:
Copy Forwarded On:	Copies sent to: