COUNTY OF SAN LUIS OBISPO
DEPARTMENT OF HUMAN RESOURCES

ADA CERTIFICATION FORM

EMPLOYEE – Reasonable Accommodation Request

Employee Name:	Employee Number:	Today's Date:
Job Title:	Email Address:	
Department: Please select your 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

COUNTY OF SAN LUIS OBISPO
DEPARTMENT OF HUMAN RESOURCES
ADA CERTIFICATION FORM

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 EMPLOYEE

Employee Name:	Employee Number: Date of Birth:
Job Title:	Department: Please select your 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 HEALTH CARE PROVIDER

Health Care Provider Name:	License Number:
Address:	Specialization/Type of Practice:
Phone Number:	Fax Number:

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 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. **Does the employee/patient have a physical or mental impairment that limits their ability to perform any of their job functions?** ❑ Yes ❑ No
2. ***(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?**
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:

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

COUNTY OF SAN LUIS OBISPO
DEPARTMENT OF HUMAN RESOURCES

ADA CERTIFICATION FORM

Employee Name: _____ Employee Number: _____

HEALTH CARE PROVIDER – ADA Certification Form (Continued)

To be completed by **HEALTH CARE PROVIDER**

Physical Activity	Permanent Limitation	Temporary Limitation	If temporary, what is the duration of the limitation? (Please include any comments)
Sitting	❑	❑	
Standing	❑	❑	
Walking	❑	❑	
Bending Over	❑	❑	
Climbing	❑	❑	
Pushing & Pulling	❑	❑	
Crouching/Stooping	❑	❑	
Reaching Overhead			
· Right	❑	❑	
· Left	❑	❑	
Kneeling			
· Right	❑	❑	
· Left	❑	❑	
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	❑	❑	
· Left	❑	❑	
Simple/Light Grasping			
· Right	❑	❑	
· Left	❑	❑	
Firm/Strong Grasping			
· Right	❑	❑	
· Left	❑	❑	
Fine Motor			
· Right	❑	❑	
· Left	❑	❑	

Indicate Level of Mental, Emotional, and Sensory Limitation:

Pace of Work	❑ Fast ❑ Avg ❑ Below Avg	Hearing	❑ Mild ❑ Moderate ❑ Severe
Manage Multiple Priorities	❑ Mild ❑ Moderate ❑ Severe	Reading	❑ Mild ❑ Moderate ❑ Severe
Intense Customer Interaction	❑ Mild ❑ Moderate ❑ Severe	Analyzing	❑ Mild ❑ Moderate ❑ Severe
Multiple Stimuli	❑ Mild ❑ Moderate ❑ Severe	Verbal Communication	❑ Mild ❑ Moderate ❑ Severe
Frequent Change	❑ Mild ❑ Moderate ❑ Severe	Written Communication	❑ Mild ❑ Moderate ❑ Severe
Short-term Memory	❑ Mild ❑ Moderate ❑ Severe	Vision	❑ Mild ❑ Moderate ❑ Severe
Long-term Memory	❑ Mild ❑ Moderate ❑ Severe	Attention Span	❑ Mild ❑ Moderate ❑ Severe
Reasoning	❑ Mild ❑ Moderate ❑ 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):_____ ❑ Yes ❑ No

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Employee Name: _____ Employee Number: _____

HEALTH CARE PROVIDER – ADA Certification Form (Continued)

To be completed by **HEALTH CARE PROVIDER**

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:

❑ 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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