Reasonable Accommodation Request

& Authorization for Medical Information

TO BE COMPLETED BY EMPLOYEE/CANDIDATE

If you are a County employee or job candidate with special needs from a disability and you believe that reasonable accommodations will assist you in the performance of your job, please complete this request form. Detailed information will ensure the County's ability to assist you. Provide your physician with this form (or a copy), a Physician's Medical Certification for Reasonable Accommodation form, and your job description. Return both completed forms to Tehama County Personnel at the contact information below. All requests and medical certifications will be kept in a confidential medical file. [Tehama County Personnel Rule §6302: Reasonable Accommodation]

Employee or Candidate Name:		Employee Payroll ID#:
Position:	Dept/Dept. Code:	
Work Email:	Personal Email:	Cell Phone:
Supervisor:	Supervisor Phone or Email:	
Current work schedule (days and hours):		
Physician name and contact information:		

Use the back of this form if you need additional space to provide the information below.

Nature of qualifying disability: Describe the nature, extent and duration of your disability.
Requested/suggested accommodation: Describe the accommodations you believe are needed to enable you to perform the essential functions of the job. Be specific as possible. (For example, if requesting a device, provide description, manufacturer, cost, vendor, etc.)
Reason for request: Describe how the requested accommodations will enable you to perform your job now or in the future.

Employee/Candidate Authorization: I authorize my medical provider to release information from my patient file to the County of Tehama for the purpose of exploring reasonable accommodation under ADA/FEHA. I also grant the County of Tehama permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act (ADA) and Fair Employment and Housing Act (FEHA). This may include communication with appropriate County personnel and/or my health care professional. I understand that all information obtained during this process will be maintained and used in accordance with ADA/FEHA confidentiality requirements and all requests and medical certifications will be kept in a confidential medical file. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job.

Signature:	Date:

Return completed form, along with Physician's Medical Certification to:

Tehama County Personnel, 727 Oak Street, Suite 105, Red Bluff, CA 96080 or Confidential Fax: 530-527-9562

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Physician Certification for Reasonable Accommodation

TO BE COMPLETED BY HEALTHCARE PROVIDER

Employee or Candidate Name:	DOB:	Employee Payroll ID#:
Position:	Dept/Dept. Code:	

Healthcare Provider: Attached is the employee/candidate's and request for accommodation and job description. The job description indicates the essential functions of the position, the physical/mental demands, and the environmental conditions associated with the job. Please review this information prior to completing this form. (If you did not receive the job description, please contact Tehama County Personnel at 530-527-4183.)

Physician:	Specialty/Type of Practice:	
License #:	Phone:	Fax:
Address:		

Determination of a qualifying disability: A person has a qualifying disability under the ADA/FEHA if the person has an impairment that substantially limits one or more major life activities.

Does the employee/candidate have a physical or mental impairment?	☐ no ☐ yes
Is this a condition which requires periodic visits for treatment by a healthcare provider?	☐ no ☐ yes
Is this a condition which cause episodic rather than continued period of incapacity?	☐ no ☐ yes
Is the patient taking medications or treatments which would be expected to affect job performance and/or would pose a direct threat or safety risk?	☐ no ☐ yes
Does the impairment substantially limit one or more major life activities?	☐ no ☐ yes
Is this condition due to a work related injury that occurred while working for Tehama County? If yes, date of injury (if known):	☐ no ☐ yes

Determination of whether an accommodation is needed:

What is the limitation that is interfering with this employee/candidate's ability to do their job?
What essential job function in the job description is the employee/candidate having trouble performing due to the limitation?
How does the limitation interfere with the employee/candidate's ability to do their job?

Determination of effective accommodation options:

Do you have any suggestions regarding possible accommodations to improve the employee/candidate's ability to do their job?

Indicate physical limitations:

Climbing stairs/ladder	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Walking/standing	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Overhead work/reaching	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Bending/stooping	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Kneeling/squatting	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Sitting	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Grasping/squeezing	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Repetitive use of hands	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Keyboarding	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Driving	☐ No limitations	☐ Permanent	☐ Temporary, likely end date:
Pushing/pulling	☐ No limitations	☐ Permanent Limited to ____ pounds	☐ Temporary, likely end date:
Lifting/Carrying	☐ No limitations	☐ Permanent Limited to ____ pounds	☐ Temporary, likely end date:
Are restrictions specific to a specific body part (left hand, right ankle, etc.)? If so describe:			
Other restrictions (length of workday, number of stretch breaks, etc.):			

Indicate mental, emotional, and sensory limitations:

Pace of work	☐ No limitations	☐ Fast	☐ Average	☐ Below Average
Manage multiple priorities	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Intense customer interaction	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Multiple stimuli	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Frequent change	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Short-term memory	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Long-term memory	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Attention span	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Reasoning	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Hearing	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Reading	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Analyzing	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Verbal communication	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Written communication	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe
Vision	☐ No limitations	☐ Mild	☐ Moderate	☐ Severe

Leave of absence as a reasonable accommodation for employee:

If request is for an extended leave of absence beyond mandated FMLA/CFRA leave, please specify estimated date employee will return to work. (If unknown, provide closest estimated date.)
When the employee returns, will he/she be able to complete the essential functions of the job? ☐ no ☐ yes:
If no, please explain long and short term limitations and accommodations needed.

Additional comments, if any:

Physician Attestation: As the employee/candidate's physician, I certify that the employee has a physical, mental, or emotional impairment that limits one or more major life activities.

Physician Signature:	Date:

Return form to:

Tehama County Personnel, 727 Oak Street, Suite 105, Red Bluff, CA 96080 or Confidential Fax: 530-527-9562