MEDICAL CERTIFICATION FOR EMPLOYEE REQUESTING A REASONABLE ACCOMMODATION

DO NOT INCLUDE DIAGNOSIS

SECTION A: TO BE COMPLETED BY THE EMPLOYEE	
Employee Name & ID Number	Classification/Job Title
Work Location/Supervisor & Supervisors Telephone	Personal Telephone/Email
Accommodation(s) Requested (Be as specific as possible, for example adaptive equipment, reader, interpreter, training, schedule change, etc.):	
Reason for request (Please do not disclose your diagnosis; explain your disability-related limitations and how this accommodation will help you do your job.)	
Is your limitation: ❑ Permanent ❑ Temporary ❑ Long term	Anticipated recovery date:
Is the above described disability due to a worker's compensation claim? (Employees with work related injuries may also be eligible for a reasonable accommodation independent of the worker's compensation process.) Yes ❑ No ❑ If Yes, Date Filed:	
Have you requested FMLA, CFRA, PDL or other leave in connection with the above described disability? Yes ❑ No ❑ IF YES, please specify when:	
Work schedule:	
I certify that I have a disability that requires reasonable accommodation, which will be met by the accommodation(s) listed above.	
Employees Signature	**Date**

SECTION B: TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER:

A. Questions to help determine whether an employee needs a reasonable accommodation.

For reasonable accommodation, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability that requires a reasonable accomodation at work:

Does the employee have a physical or mental impairment?	Yes ❑	No ❑
Approximate date the impairment commenced?		
Probable duration of condition?		

Does the impairment substantially limit any or all functional limitations? Yes ❑ No ❑

If *yes*, describe the employee's limitations when the impairment is active. (Do not include diagnosis)

Is their limitation:

❑ Permanent ❑Temporary ❑Long term

Please include in your report any and all functional limitations for.

❑NO repetitive lifting/carrying of _____lbs. or more
❑NO lifting/carrying of _____lbs. or more
❑NO prolonged standing in excess of ____hours
❑NO repetitive pushing / pulling of _____lbs. or more
❑NO repetitive keyboarding in excess of ____minutes per hour
❑Other: (please be specific)_____

❑NO prolonged sitting in excess of ____hours
❑NO repetitive bending / stooping
❑NO at or above shoulder level
❑NO running / jumping / climbing
❑NO repetitive squatting / kneeling

B. Questions to help determine why a reasonable accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

Why does the employee need reasonable accommodation? (e.g., obtaining medical treatment, recovering from a flare up, training in the use of a service animal, avoiding temporary adverse conditions in the work environment)

C. Questions to help determine whether other accommodations might be effective.

If an employee has a disability and needs a reasonable accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. However, the employer gets to choose among effective accommodation options. The following questions may help determine effective accommodation options:

Is there a possibility the employee could work if reasonable accommodations other than leave were provided? Yes ❑ No ❑

If yes, do you have any suggestions regarding those possible reasonable accommodations?

D. Additional information or comments

Medical Provider Signature:	**Date:**
Printed Name of Medical Provider:	**Type of Practice:**
Address:	**Telephone Number:**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.