San Diego Community College District
3375 Camino del Rio South, San Diego, CA 92108
People, Culture, and Technology Services | Employee Relations Office | Phone: 619-388-6576

Reasonable Accommodation Request Form

Section A-1: To Be Completed by the Employee

Employee Name: _____ Employee ID: _____

1. I am requesting a reasonable accommodation for a physical or mental impairment because (*choose one only*):
   - ☐ I have been offered employment. The accommodation requested would allow me to perform the essential functions of the position I have been offered based on the Classification description/desk duties I have been provided.
   - ☐ I am currently an employee and the accommodation requested would allow me to perform the essential function duties of my current position based on the Classification description/desk duties I have been provided.

2. My specific function limitation(s) is:

   _____

   _____

3. Describe the accommodation being requested below. If it is a specific modification to your job duties or schedule, please list such information below:

   _____

   _____

   _____

4. What is the requested and anticipated duration of your requested accommodation?

   _____

   _____

5. Describe how this accommodation will assist you (please attach additional sheets as necessary):

   _____

   _____

   _____

6. Is your limitation:
   ☐ Permanent ☐ Temporary

7. Have you requested FMLA, CFRA, PDL, or any other leave in connection with the disability described above? ☐ Yes ☐ No

Employee Signature _____ Date _____

For HR Use Only

Received by: _____ Date Received: _____

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Authorization for Use or Disclosure of Medical Information

Section A-2: To Be Completed by the Employee

Employee Name: _____ Employee ID: _____

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et. Seq.

Authorization

I hereby authorize _____ (name of physician, hospital or health care provider) to furnish to San Diego Community College District's Human Resources Division information pertaining to my request for accommodation for a physical or mental impairment.

Uses

This authorization is limited to the following information. Certification of Health Care Provider for Reasonable Accommodation of Disability

Duration

This authorization shall become effective immediately and shall remain in effect until _____ (date).

Restrictions

I understand that the requestor may not further disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically requested or permitted by law.

Additional Copy

I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: ☐ Yes ☐ No

Employee Signature _____ Date _____

Healthcare Provider's Information

Name: _____ Phone: _____
Address: _____

For HR Use Only

Received by: _____ Date Received: _____

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Healthcare Provider Certification for Reasonable Accommodation of Disability

Section B-1: To Be Completed by Physician/Healthcare Provider

Employee Name: _____ Employee ID: _____

The San Diego Community College District is attempting to provide a reasonable accommodation for the above individual. The information requested below is confidential and will only be used to determine whether SDCCD can accommodate this individual and/or determine appropriate means for a reasonable accommodation.

Please answer the following questions with respect to the individual's request for reasonable accommodation. A copy of the employee's or applicant's job description, which includes the essential physical and mental requirements and working conditions of the position, has been enclosed to facilitate your review.

Please do not provide any underlying diagnosis or medical condition.

1. Is the employee disabled? ☐ Yes ☐ No
2. If you answered affirmatively, does this individual have any limitations that impair their ability to perform the duties of the position as a result of the disability? ☐ Yes ☐ No

   If yes, describe the limitation in detail.

_____

_____

_____

3. What is the anticipated duration of each limitation? (Please indicate whether the limitations are temporary or permanent. If they are temporary, please state when they are expected to end.)

_____

_____

_____

4. Do the limitation(s) impair the individual's ability to perform the job, as indicated in the mental and physical requirements section of the enclosed job description? ☐ Yes ☐ No

   If yes, please explain in the detail with respect to each requirement:

_____

_____

_____

If yes, on the table that follows on page 4, please check the specific physical/mental activity that is restricted and enter the maximum number of hours per day the individual may perform that activity or if the individual is restricted from performing that activity, please indicate so.

Section B-2: To Be Completed by Physician/Healthcare Provider

	Physical Activity	Max Hours		Physical Activity	Max Hours
☐	Sitting		☐	Kneeling	
☐	Standing		☐	Repeated bending from the waist	
☐	Walking		☐	Crawling	
☐	Lifting (max weight of _____ lbs)		☐	Repetitive finger movement	
☐	Carrying (max weight of _____ lbs)		☐	Repetitive twisting or pressure involving wrist or hands	
☐	Pushing (max weight of _____ lbs)		☐	Use of both hands	
☐	Pulling (max weight of _____ lbs)		☐	Use of both legs	
☐	Reaching above shoulder height		☐	Balancing	
☐	Reaching below shoulder height		☐	Stooping/squatting	
☐	Climbing stairs		☐		
☐	Climbing ladders		☐		

5. Please provide your recommendations of specific accommodations:

_____

_____

_____

6. Additional comments:

_____

_____

_____

Physician's Name: _____ Phone: _____

Signature: _____ Date: _____

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Section C: To Be Completed by the Employer

Employee Name: _____ Employee ID: _____

1. List specific accommodation(s) to be provided:

_____

_____

_____

2. For each accommodation requested by the employee that you deny, explain the reason for the denial:
   - ☐ Accommodation ineffective.
   - ☐ Accommodation would cause undue hardship. Identify undue hardship: _____
   - ☐ Medical documentation is inadequate.
   - ☐ Accommodation would require removal of an essential function of the job. Identify function: _____
   - ☐ Accommodation would require lowering of performance or production standard. Identify standard: _____
   - ☐ No alternative vacant position available. Positions considered: _____
   - ☐ Employee rejected alternative accommodation. Identify accommodation offered and reason for employee's rejection: _____ _____
   - ☐ Other (please identify): _____ _____ _____

3. Further notes/explanations/comments:

_____

_____

_____

Acknowledgement of receipt of Reasonable Accommodation _____
Date Accommodation Begins: _____
Date Accommodation Ends: _____

For HR Use Only

Received by: _____ Date Received: _____