

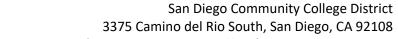
## **Reasonable Accommodation Request Form**

Section A-1: To Be Completed by the Employee				
Emplo	oyee Name: Employee ID:			
1.	<ul> <li>I am requesting a reasonable accommodation for a physical or mental impairment because (<a href="mailto:choose one only">choose one only</a>):</li> <li>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.</li> <li>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.</li> </ul>			
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 H	R Use Only			
Received by: Date Received:				



### **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 has been seen that the confidentiality of Medical Information Act of 1981, Civil (	on is being requested of you to comply with the terms of				
Authorization hereby authorize or health care provider) to furnish to San Diego Commun nformation pertaining to my request for accommodation	ity College District's Human Resources Division				
<u>Jses</u> This authorization is limited to the following information. Accommodation of Disability	. Certification of Health Care Provider for Reasonable				
<u>Duration</u> This authorization shall become effective immediately an	nd shall remain in effect until (date).				
Restrictions understand that the requestor may not further disclose s obtained from me or unless such use or disclosure is sp					
Additional Copy further understand that I have a right to receive a copy requested and received:	of this authorization upon my request. Copy				
Employee Signature	Date				
Healthcare Provide	er's Information				
Name: Address:	Phone:				
For HR Use Only					
Received by:	Date Received:				

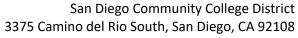




# Healthcare Provider Certification for Reasonable Accommodation of Disability

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.						
<ol> <li>Is the employee disabled?  Yes</li> <li>If you answered affirmatively, does this perform the duties of the position as a</li> </ol>	☐ No individual have any limitations that impair their ability to result of the disability? ☐ Yes ☐ No					
If yes, describe the limitation in detail.						
•	h limitation? (Please indicate whether the limitations are mporary, please state when they are expected to end.)					
4. Do the limitation(s) impair the individua physical requirements section of the en	al's ability to perform the job, as indicated in the mental and closed job description?					
If yes, please explain in the detail with r	respect to each requirement:					
	ase check the specific physical/mental activity that is hours per day the individual may perform that activity or if					

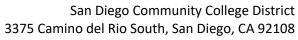
the individual is restricted from performing that activity, please indicate so.





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

	Physical Activity	Max Hours	Physical Activity	Max Hours	
Sit	ting		Kneeling		
Sta	anding		Repeated bending from the waist		
☐ Wa	alking		Crawling		
Lift	ting (max weight of lbs)		Repetitive finger movement		
	rrying (max weight of lbs)		Repetitive twisting or pressure involving wrist or hands		
☐ Pu:	shing (max weight of lbs)		Use of both hands		
☐ Pu	lling (max weight of lbs)		Use of both legs		
Re	aching above shoulder height		Balancing		
Re	aching below shoulder height		Stooping/squatting		
Cli	mbing stairs				
Cli	mbing ladders				
5. Please provide your recommendations of specific accommodations:					
6. Additional comments:					
Physicia	an's Name:		Phone:		
, 5 . 6 . 6					
Signature:			Date:		





Section C:	: To Be Completed by the Employer						
Employee Nan	ne:	Employee ID:					
1. List spe	1. List specific accommodation(s) to be provided:						
<ol> <li>For each accommodation requested by the employee that you deny, explain the reason for the denial</li></ol>							
	Accommodation would cause undue hardship. Ident	cify undue hardship:					
☐ Medical documentation is inadequate.							
	Accommodation would require removal of an essential function of the job. Identify function:						
	<ul> <li>Accommodation would require lowering of performance or production standard.</li> <li>Identify standard:</li> </ul>						
	No alternative vacant position available. Positions considered:						
	Employee rejected alternative accommodation. Identify accommodation offered and reason for employee's rejection:						
	Other (please identify):						
3. Furthe	r notes/explanations/comments:						
Date Acco	edgement of receipt of Reasonable Accommodation ommodation Begins:ommodation Ends:						
For HR Use Or	nly						
Received by:		Date Received:					