State Center Community College District

1171 Fulton Street • Fresno, California 93721 • (559) 243-7100 • FAX (559) 499-6006

www.scccd.edu

REQUEST FOR REASONABLE ACCOMMODATION

Employee Questionnaire

Name	
Department	
Position title	
Email address	
Phone numbers (home, office and cell)	
Supervisor's Name	

Please complete the following:

1. What job duties, if any, are you having difficulty performing?

2. What restriction(s) or limitation(s) is interfering with your ability to perform your job or access an employment benefit?

   Have you had any accommodations in the past for this same restriction or limitation? ☐ YES ☐ NO
   If *yes*, what were they and how effective were they?

3. Is there any additional information that you would like the District to be aware of that may assist in this process? Please do not provide any information on your diagnosis, condition or treatment.

4. Is this for a Workers' Compensation injury or illness? ☐ YES ☐ NO If yes, please list date of injury: _____

I certify that the above is true and accurate.

Employee Signature Date

Received in HR by:

Signed Print Name Date Received

REQUEST FOR REASONABLE ACCOMMODATION

Healthcare Provider Questionnaire

Your patient is in the process of requesting reasonable accommdoations from State Center Community College District (SCCCD) to assist them to perform the essential functions of their position safely or to care for an immediate family member. In compliance with the Fair Employment and Housing Act (FEHA) (Government Code § 12940) and Title I of the Americans with Disabilities Act (42 U.S.C. § 12101, et seq.), your assistance is requested to provide information in support of this request. Please answer the following questions and provide the completed questionnaire to your patient, who will return it to the District's Human Resources Analyst, Accommodations for use in their interactive process.

Healthcare Provider's Name: _____

Healthcare Provider's Phone Number: _____

Date of Examination: _____

Employee's Name: _____

Patient's Name (If other than employee): _____

Patient's relationship to employee: _____

Date medical condition of employee or employee's immediate family member: _____

Date medical condition or need for treatment commenced: _____

[NOTE: THE HEALTHCARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT]

Please answer the following questions if they relate to the employee's work restrictions functional limitations to the essential functions of their position or for an immediate family member as they relate to a qualifying medical condition under the Americans with Disabilites Act (ADA) or Fair Employment and Housing Act (FEHA). If provided, please review the Job Description for your patient, and provide the following clarification:

(Check boxes as appropriate. Additional comments may be added under number 10)

1. Does your patient have a physical or mental impairment that limits their ability to engage in a major life activity, such as the ability to work, care for themself, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities? Pursuant to the FEHA amendments that went into effect on January 1, 2001, a condition can be said to "limit" one if the condition makes the achievement of the major life activity more difficult.

   ☐ NO, my patient does not have a physical or mental impairment that limits their ability to engage in a major life activity.

   ☐ YES, my patient has a ☐ PHYSICAL and/or ☐ MENTAL impairment that limits their ability to engage in a major life activity.

2. If the answer to question number one (1) is yes, does the impairment currently affect your patient's ability to perform the essential functions of their position (see attached job description).

   ☐ NO, my patient's impairment does not limit their ability to perform all of the essential functions of their position.

   ☐ YES, my patient's impairment does affect their ability to perform the essential functions of their position.

3. If the answer to question number two (2) is yes, what work restriction(s) or functional limitation(s) does their disability produce that are in need of accommodation? Please be as specific as possible. (e.g. if providing a restriction to standing, how many minutes can they stand before they would need to sit for X minutes, etc.) **List all necessary work restrictions with sufficient detail so all parties will understand how to interpret and apply them:**

   ☐ Restrictions are **TEMPORARY through _____ (date)** ☐ Restrictions are **PERMANENT**

   Please mark all that apply:

   ☐ Maximum lifting/carrying of _____ pounds per _____ right _____ left _____ both arms and _____ minutes per hour____ hours per day

   ☐ Maximum repetitive lifting/carrying of ____ pounds or more (Repetitive can be characterized by one of the following: A cycle time less than 30 seconds; over 1,000 parts per shift; or, more than 50% of the cycle time involving the same kind of fundamental cycle.)

☐ NO bending more than ____ times in a row and ____ minutes per hour
☐ NO twisting of the waist more than ____ minutes at one time and ____ minutes per hour
☐ NO stooping more than ____ minutes at one time and ____ minutes per hour
☐ NO squatting more than ____ minutes at one time and ____ minutes per hour
☐ NO kneeling more than ____ minutes at one time and ____ minutes per / ____ right ____ left ____ both knees
☐ NO pushing/pulling of ____ pounds of force per ____ right ____ left ____ both arms and ____ minutes per hour____ hours per day
☐ NO standing in excess of ____ minutes at one time and ____ minutes per hour ____ hours per day
☐ NO sitting in excess of ____ minutes at one time and ____ minutes per hour ____ hours per day
☐ NO walking in excess of ____ minutes at one time and ____ minutes per hour ____ hours per day
☐ Restricted above shoulder level reach for ____ minutes at one time per ____ right ____ left ____ both arms and ____ minutes per hour____ hours per day
☐ Must alternate sitting/standing after ____ minutes of per hour ____ hours per day
☐ NO running or ☐ no running more than ____ minutes at one time and maximum minutes per day
☐ NO jumping
☐ NO climbing of stairs or steps or ☐ limit stairs and steps to ____ steps at one time
☐ Maximum keyboarding/data entry at one time to ____ minutes, ____ minutes per hour and ____ hours per day
☐ Hand use limitations (Please indicate if right, left or both hands):

_____

☐ Neck motion limitations:

_____

☐ Other: (list below)

_____

_____

4. Is it medically necessary for your patient to be off work on an intermittent basis due to their serious health condition or to care for an immediate family member?

☐ NO, my patient does not need to be off work on an intermittent basis due to their serious health condition or to care for an immediate family member.
☐ YES, my patient does need to be off work on an intermittent basis due to their serious health condition or to care for an immediate family member.

If yes, please indicate the estimated frequency of the patient's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

5. Is a reduced schedule leave medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee or family member?

☐ NO, my patient does not need to a reduced schedule due to their serious health condition or to care for an immediate family member.
☐ YES, my patient does need a reduced schedule due to their serious health condition or to care for an immediate family member.

If yes, please indicate the part-time or reduced work schedule the employee needs:
_____ hours per day; or _____ day(s) per week from _____ through _____

6. Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

☐ NO, my patient does not need to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services.
☐ YES, my patient does need to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services.

If yes, please indicate the estimated frequency of the employee's need for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hours or _____ day(s) per appointment/treatment

7. Does your patient's continued assignment to their job pose a significant risk of substantial harm to the health and safety of the employee or others?

☐ NO ☐ YES, complete questions # 8 and # 9 below.

8. If the answer to question number seven (7) is yes, identify the duration, nature, severity, likelihood and imminence of each specific risk.

_____

_____

_____

9. If the answer to question number seven (7) is yes, identify any specific work restrictions(s), that if accommodated, would reduce or eliminate the risk(s) described in question number eight (8).

_____

_____

_____

10. Additional Restrictions / Accommodation Suggestions / Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee.

_____

_____

_____

If the certification is for the care of the employee's family member, please answer the following:

1. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?

☐ NO, the patient will not require assistance for basic medical, hygiene, nutritional needs, safety, or transportation.
☐ YES, the patient will require assistance for basic medical, hygiene, nutritional needs, safety, or transportation.

2. Does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

☐ NO, the condition will not warrant the participation of the employee.
☐ YES, the condition will warrant the participation of the employee nutritional needs, safety, or transportation.

_____

Physician Signature Date

Please return this completed form to your patient and/or fax to Sandi Edwards, Human Resources Analyst at (559) 499-6006

---Serious Health Condition---

"Serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

1. **Hospital Care**: Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an "inpatient" when a heath care facility formally admits him or her to the facility with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

2. **Absence Plus Treatment**:
   (a) A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

      (1) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

      (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. **Pregnancy**: Any period of incapacity due to pregnancy, or for prenatal care. [NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA]:

4. **Chronic Conditions Requiring Treatment**: A chronic condition which:
   (a) Requires periodic visits for treatment by a health care provider, or by a nurse of physician's assistant under direct supervision of a health care provider;
   (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   (c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. **Permanent/Long-term Conditions Requiring Supervision**: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments** (Non-Chronic Conditions): Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

Note: Authority cited: Section 12935(a), Government Code. Reference: Section 12945.2, Government Code; California Genetic Information Nondiscrimination Act, Stats. 2011, ch. 261; Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; and 29 C.F.R. § 825.