County of Imperial
Reasonable Accommodation

In accordance with California's Fair Employment and Housing Act (FEHA) and the Americans with Disabilities Act (ADA), the County of Imperial provides reasonable accommodations to qualified employees with disabilities, unless to do so would be an undue hardship. Reasonable Accommodation is a change in the job, work environment, or processes to enable those employees to perform the essential functions of their job.

EMPLOYEE INSTRUCTIONS:

1. Complete and sign the Reasonable Accommodation Request Form
   - Answer all the questions/fill in all the blanks.
   - DO NOT state your medical condition or diagnosis.
   - Provide your current contact information.
2. Ask your health care provider to complete the Physician Certification for Reasonable Accommodation
   - It is important your health care provider identify restrictions/limitations. If not, it may result in a delay with implementing an effective accommodation. A restriction is a description of a limitation or need of an individual that may impact their ability to perform the essential functions of the position or assignment.
3. After both forms are complete, return all completed forms to the Department of Human Resources and Risk Management via e-mail or regular mail. Please contact us to provide you with the email address.

940 W. Main St. – Suite 101
El Centro, CA 92243
(442) 265-1148

HEALTH CARE PROVIDER INSTRUCTIONS:

1. Review and complete the Physician Certification for Reasonable Accommodation
   - Review that your patient/our employee has signed an authorization for the release of this information. All information is held strictly confidential in accordance with relevant laws and regulations.
   - Print legibly and sign. Incomplete forms, illegible information, or only providing an accommodation (not restrictions/limitations) may cause further communication with you and a delay in your patient/our employee receiving a reasonable accommodation.
   - DO NOT state a medical condition or diagnosis.
2. **Please complete and return this notice to your patient before she/he leaves your office.**

Reasonable Accommodation Request Form
& Authorization for Medical Information

TO BE COMPLETED BY EMPLOYEE

If you are a County employee with a disability and you believe that a reasonable accommodation would assist you in performing the essential functions 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 County of Imperial Human Resources and Risk Management Department at the contact information below.

Employee Name:		Employee ID#:
Position:	Department:	
Work Email:	Personal Email:	Cell Phone:
Supervisor:	Supervisor Phone or Email:	
Physician name and contact information:		

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

In your current position, what tasks and duties are you unable to accomplish because of your disability?
Requested/suggested accommodation: Describe the accommodations you believe could enable you to perform the essential functions of the job. Be specific as possible, DO NOT identify a medical diagnosis/condition.
Reason for request and duration: Describe how the requested accommodation might enable you to perform your job now or in the future. Include the duration of the request.

Employee Authorization: I authorize my medical provider to release information from my patient file to the County of Imperial for the purpose of exploring reasonable accommodation under ADA/FEHA. I also grant the County of Imperial 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. 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. I understand that the County will use my proposed accommodation as an initial starting point for the interactive process.

Signature:	Date:

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

Human Resources & Risk Management, 940 W. Main St. Suite 101, El Centro, CA 92243.

Physician Certification for Reasonable Accommodation

TO BE COMPLETED BY HEALTHCARE PROVIDER

Employee Name:	DOB:
Position:	Department:

Healthcare Provider: Attached is the employee's 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 County of Imperial – Human Resources and Risk Management at (442) 265-1148)

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
Does the impairment substantially limit one or more major life activities?	☐ 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

Determination of whether an accommodation is needed:

What is the limitation/restriction that impairs/precludes the employee's ability to do their job?
What essential job functions in the job description is the employee having trouble performing due to the limitation/restriction?
How does the limitation interfere with the employee's ability to do their job?

Please indicate if the above-mentioned limitations/restrictions are:

☐ Temporary, end date: _____

☐ Permanent

Determination of effective accommodation options:

Do you have any suggestions regarding possible accommodations to improve the employee's ability to do their job? Please be very specific and include the time frame.

Physician Attestation: As the employee's physician, I certify that the employee has a physical, mental, or emotional impairment that limits one or more major life activities. I certify the above information is accurate and provided for purposes of evaluating a FEHA accommodation.

Physician Signature:	Date:

Please complete and return this notice to your patient before she/he leaves your office.