



MEDICAL PROVIDER ADA JOB ACCOMMODATION REQUEST DISABILITY VERIFICATION FORM

NAME OF PATIENT/EMPLOYEE:	DATE:
a qualified individual with a disability who ma	king a determination as to whether the above named employee is ay be considered for reasonable accommodations, we require the reference a copy of the employee's position description, which with this employee's position.
QUESTIONS TO HELP DETERMINE WHETHER	R AN EMPLOYEE HAS DISABILITY
things usually are done, that enables a qualif	ation or adjustment to a job, the work environment, or the way fied individual with a disability to enjoy an equal employment reasonable accommodation remove Essential Functions of the job.
following body systems: Neurological, muscle cardiovascular, reproductive, digestive, geni Any mental or psychological disorder such a mental illness, and specific learning disabilities. The disorder or condition is considered: In its active state, even if presently in disorder.) Without regard to the effects of mit ordinary eyeglasses.	etic disfigurement, or anatomical loss affecting one or more of the uloskeletal, special sense organs, respiratory, speech organs, itourinary, hemic and lymphatic, skin, and endocrine; or s an intellectual disability, organic brain syndrome, emotional or
Certification of Qualifying Disability:	
_	n or include medical records. We are not qualified to determine whether an employee has a qualified disability.
Is the disability: Permanent? Temporary?	
If temporary, how long will the disability potentia	ally last?
Please provide start date: a	and end date:



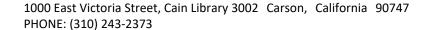
1000 East Victoria Street, Cain Library 3002 Carson, California 90747 PHONE: (310) 243-2373

Does the disability substantially li Note: Does not need to significantly or so If yes, what major life activity (s) i	everely restrict to meet this sta	Yes No andard
☐ Caring For Self☐ Interacting With Others☐ Performing Manual Tasks☐ Breathing☐ Working		ing Sleeping aking Concentrating rning Reproduction
Others: (describe) QUESTIONS TO HELP DETERMINE V		

The purpose of an accommodation is to enable the employee to return to perform the essential functions of their job. Reasonable accommodations may include but are not limited to: a modified/transitional work schedule, provision of special equipment, workplace accessibility modifications, shifting of non-essential duties of the employee's position, and a leave of absence to allow time for recovery, therapy, training, or other disability-related needs.

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	WORK LIMITATION	ONS							
Does the employee have work limit	ations: Yes	No							
Are the work limitations:	Temporary	Permanent							
What are the specific restrictions to	these limitations and the durati	ions? (see chart be	elow)						
Major Life Activity/Bodily Function	Specific Functional Limitation of specific items or issues to addr covered disability)	· · · · · · · · · · · · · · · · · · ·	Duration based on the Functional Limitation (frequency)						
Example 1: Lifting Example 2: Breathing Example 3: Standing Example 4: Interacting with others	 Avoid lifting more than 10 por Avoid heavily scented items Avoid standing on hard surface Avoid interacting with other 	or perfumes aces	 A day At all times Not to exceed 2 hours a day 1-2 days post flare ups 						

Note: Reasonable accommodations may include but are not limited to: a modified/transitional work schedule (i.e. reduced work schedule: 6 hours/day for 2 weeks, etc.), provision of special equipment, workplace accessibility modifications, shifting of non-essential duties of the employee's position, and a leave of absence to allow time for recovery, therapy or other disability-related needs.





QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

The following questions may help determine effective accommodations:

Do you have any suggestions or comments regard essential functions of their position?	ding possible	accommodations t	o ensure the	employee car Yes	n perform the No
If so, what are they?					
,					
Medical Provider Information: Medical Provider Name (Please Print): Name of Medical Practice: Address:					
City:	State:		Zip Cod	e:	
Telephone:	E-Mail:				
Medical Provider's Signature:			Date: _		
Note: Once completed, please return this form t	o Human Re	sources at the add	lress below.		
TAP Human Resources					
California State University, Domingu	iez Hills Torc)			
Auxiliary Partners					
1000 E. Victoria Street, Cain Library	3rd Floor				

3002 Carson, CA 90747

Email to: adodd@csudh.edu

^{*}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 or an embryo lawfully held by an individual or family member receiving assistive reproductive services.