Cal Poly Humboldt
Human Resources

PHYSICIANS ADA JOB ACCOMMODATION REQUEST DISABILITY VERIFICATION FORM

NAME OF PATIENT/EMPLOYEE: _____ DATE: _____

To assist the University with making a determination as to whether the above named employee is a qualified individual with a disability who may be considered for reasonable accommodations, we require the information requested in this form. You may reference a copy of the employee's position description, which sets forth the specific job duties associated with this employee's position.

QUESTIONS TO HELP DETERMINE WHETHER AN EMPLOYEE HAS DISABILITY

A "reasonable accommodation" is a modification or adjustment to a job, the work environment, or the way things usually are done, that enables a qualified individual with a disability to enjoy an equal employment opportunity. Under no circumstances does a reasonable accommodation remove Essential Functions of the job.

Disability under Americans with Disabilities Act is:

- Any physiological disorder, condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs, respiratory, speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or
- Any mental or psychological disorder such as an intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.
- The disorder or condition is considered:
    - In its active state, even if presently in remission. (Examples: epilepsy, MS, asthma, cancer, bipolar disorder.)
    - Without regard to the effects of mitigating measures such as prostheses, medication, etc. except ordinary eyeglasses.
    - With consideration of the negative effects of treatment such as medication or other measures.

Certification of Qualifying Disability:

Please do not included diagnosis information nor include medical records. We are not qualified to interpret. The following questions may help determine whether an employee has a qualified disability.

Is the disability: Permanent? ◯ Temporary? ◯

If temporary, how long will the disability potentially last?

Please provide start date: _____ and **expected** end date: _____

Does the employee have a disability, i.e., a physical or mental condition that "limits"one(1) or more major life activity? ◯ Yes ◯ No

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Does the disability substantially limit a major life activity? ☐ Yes ☐ No

Note: Does not need to significantly or severely restrict to meet this standard

If yes, what major life activity (s) is/are affected?

☐ Caring For Self	☐ Walking	☐ Hearing	☐ Lifting
☐ Interacting With Others	☐ Standing	☐ Seeing	☐ Sleeping
☐ Performing Manual Tasks	☐ Reaching	☐ Speaking	☐ Concentrating
☐ Breathing	☐ Thinking	☐ Learning	☐ Reproduction
☐ Working	☐ Toileting	☐ Sitting	

☐ Others: (describe)

QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

The purpose of an accommodation is to enable the employee to return to perform the essential functions of his/her 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.

Please provide the employee's work limitation(s):

What are the specific restrictions to these limitations and the durations? (see chart below)

Major Life Activity/Bodily Function	Specific Functional Limitation or Restriction (i.e. specific items or issues to address based on the covered disability)	Duration based on the Functional Limitation (frequency)
Example 1: Lifting Example 2: Standing Example 3: Interacting with others	**1.** Avoid lifting more than 10 pounds **2.** Avoid standing on hard surfaces **3.** Avoid interacting with others	**1.** A day **2.** Not to exceed 2 hours a day **3.** 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.

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QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

Do you have any suggestions or comments regarding possible accommodations to ensure the employee can perform the essential functions of their position? Yes ◯ No ◯

If so, what are they?

Medical Provider Information:

Medical Provider Name (Please Print): _____

Name of Medical Practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ E-Mail: _____

Medical Provider's Signature: _____ **Date:** _____

Note: Once completed, please return this form to Human Resources at the address below.

Human Resources
CalPoly Humboldt
Siemens Hall 212, 1 Harpst St.
Arcata, California 95521
OR
benefits@humboldt.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.