ADA/FEHA COVID-19 Disability Accommodation Certification

Instructions: Please note, this request form should be utilized for COVID related disability accommodations. Employee/applicant shall contact the treating health care provider to complete this form. Employee/applicant should return the completed form to ADA coordinator at HSU-HR.

To: Treating Doctor/Health Care Provider
Re: Employee/Patient Name

Treating Health Care Provider: Please complete the following:

1. Does your patient have a disability and/or medical condition that makes them “higher risk” as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19?

☐ Patient DOES NOT HAVE a disability and/or medical condition that makes them “higher risk” as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19.

☐ Patient DOES HAVE a disability and/or medical condition that makes them “higher risk” as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19. Patient is MEDICALLY RESTRICTED from coming into the workplace, even with PPE employed and social distancing being observed. (Please skip to 1.a. and #2 below and sign, date and return the form).

☐ Patient DOES HAVE a disability and/or medical condition that medically requires LIMITING their exposure to coronavirus and/or COVID-19, but not “higher risk” as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19 (Please continue completing the form)

a. PLEASE IDENTIFY ALL APPLICABLE DISABILITY/MEDICAL EMPLOYEE/PATIENT RESTRICTIONS:

__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

2. DURATION OF COVID-19 RELATED RESTRICTIONS: Please confirm the duration of restrictions by checking the appropriate box below:

☐ Restrictions are TEMPORARY through ____________ (date)

☐ Restrictions are PERMANENT

☐ Restrictions are expected to continue as follows (please explain): __________________________

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__________________________________________________________
__________________________________________________________

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b. PLEASE IDENTIFY WORKPLACE **RISKS** THAT NEED TO BE ACCOMMODATED OR MITIGATED TO ENSURE A SAFE WORK ENVIRONMENT FOR YOUR PATIENT. WHAT IS IN THE PHYSICAL WORKPLACE THAT IS A MEDICAL RISK FOR YOUR PATIENT:

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c. PLEASE IDENTIFY WORKPLACE **FACTORS** THAT MUST BE PRESENT IN A WORKPLACE TO ENSURE YOU’RE YOUR PATIENT IS SAFE. **WHAT ACCOMMODATIONS** NEED TO BE IMPLEMENTED FOR YOUR PATIENT IN ANY WORK ENVIRONMENT THEY WORK IN?

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3. **CURRENT WORK ENVIRONMENT:** HSU will/can implemented the following social distancing and cleaning protocols which meet or exceed OSHA and CDC guidelines for workplace safety:

- Plexiglass separations between the public and employee workstations
- Persons sit no less than 6 feet from each other
- Staffing off-shifting, approximately 50% of the staff are in the office at one time
- Restrooms are cleaned every hour
- Etc.

The above list of safety measures will/can be taken to protect your patient and their colleagues as their work has been deemed mission critical/essential to the business. Are the above measures sufficient to support your patient’s to return to the workplace:

- [ ] YES, the above measures are sufficient to support my patient to return to the workplace.
- [ ] NO, the above measures are insufficient to support my patient to safely return to the workplace. The following safety precautions also need to be implemented/present: ____________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
4. **COMMUTE QUESTION:** Is your patient’s request for a work-from-home accommodation related to his/her commute?

- □ NO, the recommendation for an accommodation is NOT related to my patient’s commute.
- □ YES, the recommendation for an accommodation IS related to my patient’s commute. The commute concern relates to: □ he/she uses public transportation or □ other, explain: __________________________________________________________________________
  __________________________________________________________________________
  __________________________________________________________________________

5. **PERSONAL PROTECTION EQUIPMENT CLARIFICATION:**

a. Does your patient medical condition require specific personal protection equipment?

- □ NO, Patient’s medical condition **DOES NOT** require specific personal protection equipment.
- □ YES, Patient’s medical condition **DOES** require specific personal protection equipment as follows (check all that apply):
  □ Medical Mask
  □ Respirator with rating greater than: ____________
  □ Face Shield
  □ Hand Gloves
  □ Eye Protection
  □ Gowns
  □ Aprons
  □ Eye Protection
  □ Footwear Covers
  □ Other: __________________________________________________________________________
  __________________________________________________________________________
  __________________________________________________________________________
  __________________________________________________________________________
6. **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. **Please do not list any information pertaining to medical condition or diagnosis.**

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Date

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Doctor/Healthcare Provider Print

Doctor/Healthcare Provider Signature

License Number

________________________________________________________________________

Healthcare Provider Address

 Verified by ADA Coordinator

Date:  

Revised 08/2020