County of Sacramento
Reasonable Accommodation Request Form

In accordance with California's Fair Employment and Housing Act (FEHA) and the Americans with Disabilities Act (ADA), the County of Sacramento 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. Reasonable Accommodation may include but is not limited to: providing leave for medical care, changing work schedules, relocating the work area, and modification of work tools and equipment.

EMPLOYEE INSTRUCTIONS:

1. Read and sign the Acknowledgment and Authorization at the top of Page 2
2. Ask your health care provider to complete the remainder of Page 2
    - 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. Upon completion of page 2, complete the Employee section of the Reasonable Accommodation Request Form (page 3).
    - Answer all the questions/fill in all the blanks.
    - DO NOT state your medical condition or diagnosis.
    - Provide your current contact information.
4. After completing page 3, return all completed forms to the Department of Personnel Services

    E-Mail: dps-medical-leaves@saccounty.gov

    US Mail: 9310 Tech Center Drive, Suite 100, Sacramento CA 95826

    Inter-Office Mail: 61-120A
5. Questions can be addressed at (916) 874-6845 (CA Relay 711) or via the e-mail address above.

HEALTH CARE PROVIDER INSTRUCTIONS:

1. Review and complete the Health Care Provider section of the Reasonable Accommodation Request Form on Page 2:
    - 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.
    - Type or 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 diagnosis.
    - DO NOT provide any genetic information as defined by the Genetic Information Nondiscrimination Act of 2008
2. Return completed forms to your patient.

Employee/Patient Authorization for Health Care Provider to Release information

I am requesting a reasonable accommodation to assist me in performing the essential functions of my job. As part of my request for reasonable accommodation, I authorize my Health Care Provider to disclose to the County of Sacramento any disability related medical restrictions/limitations of which they are aware.

Employee/Patient Signature Date

Health Care Provider to Complete:

Patient Name: Date:

1. Does your patient have an ADA/FEHA qualifying medical condition? Yes ☐ No ☐
   Information on ADA and FEHA qualifying conditions is available on the following websites:
   https://www.eeoc.gov/laws/regulations/adaaa_fact_sheet.cfm
   https://www.dfeh.ca.gov/people-with-disabilities/

2. Please describe your patient's physical, mental, cognitive, or environmental restrictions and indicate if the restriction is permanent or temporary. If temporary, include date range.

Restriction(s)	Permanent	Temporary (include date range)

_____ _____
Provider's Name (please print) Signature Provider's Signature

_____ _____
Type of Practice (field of specialization) State License #

_____ _____
Address with City, State, and Zip Area Code/Phone Number

EMPLOYEE to Complete:

Date	Employee ID#
Name	Job Title
Phone Number	E-Mail Address
Supervisor Name	Department

1. In your current position, what tasks and duties are you unable to accomplish because of your disability?

2. Based on the restrictions provided by your medical provider, what reasonable accommodation(s) could be made that would enable you to perform the tasks and duties of your position? Include suggestions for purchasable items, worksite modification, duty restructuring, etc.

ACKNOWLEDGEMENTS

This request for Reasonable Accommodation will assist me in performing the essential functions of my job. I understand that this document and medical verification will be kept in my medical file, which is separate from my personnel file. As part of my request for Reasonable Accommodation, I acknowledge:

- Medical documents may be authenticated by the County with the health care provider, but no additional information will be requested unless authorized by me.
- Additional medical information will be requested of me if the information provided is not sufficient or unclear to determine an effective and reasonable accommodation.
- Workers' Compensation will disclose any related medical restrictions/limitations, my current work status, my treatment program, and any job modifications which I have received.
- Department of Personnel Services may provide a copy of my medical file to the Sacramento County Employee Retirement System (SCERS) upon my filing an application for Disability Retirement.

Signature: Date: