Yuba Community College District
Reasonable Accommodation for Employees
Americans with Disabilities Act (ADA)
California Fair Employment & Housing Act (FEHA)

Reasonable Accommodation Healthcare Provider Certification

In accordance with FEHA/ADA, YCCD provides reasonable accommodations to qualified employees and applicants with disabilities or medical conditions, unless to do so would be an undue hardship. A reasonable accommodation is a change in the job, work environment, or processes to enable employees to perform the essential functions of their job and may include, but is not limited to, job duty modification(s), shift or schedule change(s), time off for medical care, modification to work area, and/or assistive devices or aids.

EMPLOYEE INSTRUCTIONS:

- Complete the EMPLOYEE section of this form.
- Answer all the questions/fill in all the blanks.
- DO NOT state your medical condition or diagnosis.
- Provide all of your current contact information.
- Read and sign the Acknowledgment and Authorization.
- Provide this form to your healthcare provider.
- Submit to Human Resources (contact information below) after both EMPLOYEE and HEALTHCARE PROVIDER sections are completed.

HEALTHCARE PROVIDER INSTRUCTIONS:

- Complete the Health Care Provider section of this form.
- Please type or print legibly and sign.
- Incomplete forms or illegible information will delay in the process.
- Please not provide diagnosis, medical history, or genetic information.
- Please note 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.
- Return completed forms to your patient or to the YCCD Office of Human Resources using the contact information, below.

TO SUBMIT COMPLETED FORM:

Electronic Submission: YCCD-HR@YCCD.edu (recommended)

Mail/In-Person
Office of Human Resources
Yuba Community College District
425 Plumas Blvd., Suite 200
Yuba City, California 95991

Once received, the Human Resources Office contact you to discuss the submitted documentation and next steps. If you have questions about this form/process, please submit those questions to YCCD-HR@YCCD.edu and a Human Resources Representative will contact you promptly.

EMPLOYEE TO COMPLETE:

Employee Name (Last, First, MI):	Date:
Job Title:	Immediate Supervisor:
Department:	Telephone:
Email:	Home Address:

1. **Do you have a physical or mental medical condition that is interfering with your ability to perform your job duties (including regular and timely attendance)?**

   ☐ Yes ☐ No

2. **Is your condition permanent?**

   ☐ Yes ☐ No

3. **In your current position, what tasks and duties are you unable to accomplish because of your condition?**

   _____
   _____
   _____
   _____

4. **What Reasonable Accommodation(s) do you think would enable you to perform the tasks and duties of your position? Include suggestions for purchasable items, worksite modification, duty restructuring, etc.**

   _____
   _____
   _____
   _____

5. **Do you currently have any ADA/FEHA, Workers' Compensation, or Family and Medical Leave Act (FMLA) work restrictions ordered by your Health Care Provider?**

   ☐ Yes ☐ No ☐ I do not know.

ACKNOWLEDGEMENT AND AUTHORIZATION

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 separate from my personnel file. As part of this request, I authorize my healthcare provider, whose signature appears below, to disclose to the Yuba Community College District, Office of Human Resources, any medical restriction(s) and/or limitation(s) which may impact my ability to perform my job.

_____ _____ _____

Employee Name (Printed) Employee Signature Date:

HEALTHCARE PROVIDER TO COMPLETE:

Patient Name (Last, First, MI):	Date:
Physician Name (Last, First, MI):	Specialty/Practice Name or Provider:
Address:	Telephone and Fax:

1. **Does the patient/employee have a medical condition that limits a major life activity?**

   ☐ Yes ☐ No

2. **Type of Impairment/Limitation:**

   ☐ Physical ☐ Mental ☐ Physical and Mental ☐ Other (Describe):

   _____
   _____
   _____
   _____

3. **Type of Impairment/Limitation:**

   ☐ Sitting ☐ Standing ☐ Lifting ☐ Reaching ☐ Walking ☐ Breathing
   ☐ Seeing ☐ Hearing ☐ Sleeping ☐ Thinking ☐ Communicating
   ☐ Working ☐ Interacting ☐ Caring for Oneself ☐ Other (Describe):

   _____
   _____
   _____
   _____

4. **Is the condition permanent?**

   ☐ Yes ☐ No

   If "NO," please provide its expected duration: _____

5. **Please state the patient/employee's specific health restrictions or limitations (do not provide diagnosis, medical history, or genetic information[1]):**

_____
_____
_____
_____

6. **Scheduled treatment:**

_____
_____
_____
_____

Provider Signature:_____ Date: _____

[1] 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, exceptas 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 sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family memberreceiving assistive reproductive services. 29 C.F.R. §1635.8(b)(1)(i)(B).