COUNTY OF YOLO
REQUEST FOR MEDICAL CERTIFICATION
REASONABLE ACCOMMODATION FORM

Date: _____

To: _____
(Physician or Medical Provider)

From: _____
(County of Yolo)

Subject: **REQUEST FOR MEDICAL INFORMATION**

Employee's Name: _____

Position Being Considered: _____

The above named employee has authorized Yolo County to obtain medical information needed to consider a request for reasonable accommodation. This medical information is needed for verification of a disability and evaluation of the employee's ability to perform the essential functions of the position with or without an accommodation. The requested information will be kept confidential and used only to determine if a reasonable accommodation is possible for the position under consideration.

Under the American with Disabilities Act and the California Fair Employment & Housing Act an **individual with a disability** is a person who:

- Has a physical or mental impairment that limits one or more major life activities (major life activity may include walking, breathing, speaking, performing manual task, seeing, hearing, learning, caring for oneself, sitting, standing, lifting, or reading).
- Has a record of such an impairment; or
- Is regarded as having such impairment.

SECTION A

Please take the above definition of a disability into consideration and answer the following questions:

1) Does this individual have an impairment that limits a major life activity?
Yes _____ (**If yes, please complete SECTION B of this form to describe the limitation**)
No _____

2) Is the disability permanent Yes ____ No ____ length of anticipated duration: _____

3) Using the enclosed job description, please indicate the job duties this person would have difficulty and/ or could not perform without an accommodation.

4) How does the limitation impair this person's ability to perform the job duties indicated above?

5) What would you recommend as a possible accommodation to the medical limitations noted above?

_____ _____

PHYSICIAN'S SIGNATURE **DATE**

SECTION B

INSTRUCTIONS: Please complete SECTION B of this form only if question #1 in Section A is answered "yes".

Work Restrictions: Patient is restricted from or limited in performing the following functions (check applicable activity and enter limitations, e.g., 0 hours; 1-2 hours; 2-5 hours; 6-8 hours; or other notation explaining the limitation).

[ ] Keyboard Use/ Repetitive Use of Hands:

[ ] Sit:

[ ] Stand:

[ ] Squat/ kneel:

[ ] Bend/ Stoop:

[ ] Push/ Pull:

[ ] Grasp/ Fine finger motions

[ ] Walk:

[ ] Twisting (neck/ waist):

[ ] Reaching (above & below shoulders):

[ ] Climb stairs/ Climb ladders:

[ ] Lift (please specify lifting restriction):

[ ] Carry (please specify carrying restrictions):

[ ] Repetitive Use of Foot Controls:

[ ] Any other applicable limitation: