REQUEST FOR INFORMATION UNDER CALIFORNIA FAIR EMPLOYMENT AND HOUSING ACT AND THE AMERICANS WITH DISABILITIES ACT

PHYSICIAN/HEALTH CARE PROVIDER: IN ORDER FOR SFSU TO BE ABLE TO PROPERLY EVALUATE THE INFORMATION PROVIDED, PLEASE ANSWER EACH AND EVERY QUESTION IN DETAIL. USE ADDITIONAL SHEETS WHERE NECESSARY.

Employee Name: ____

I. Certification of Qualifying Disability:

Does the employee have a disability, i.e., a physical or mental condition that "limits"[1] one or more major life activity? (See attached Guidelines for Evaluating Disabilities for more information, including definitions.)

☐ Yes ☐ No

A. If no, stop, no further information is required.

B. If yes, what is the duration of this condition (☐permanent or ☐temporary)? If temporary, for what period of time will the condition continue?

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[1] A condition "limits" a major like activity if it makes the achievement of the major life activity more difficult.

II. **<u>Limitations to Major Life Activities</u>**: If you answered yes to question I, please identify the major life activity(ies) that is/are limited. (See attached Guidelines for assistance.)

III. **<u>Limitation on Employee's Abilities to Perform Essential Functions</u>:** If you answered yes to question I, please answer in detail the following questions:

A. <u>Review the attached job description</u>.

B. After reviewing the description, please indicate whether the employee can perform the essential functions of the position **without** reasonable accommodation.

☐ Yes ☐ No

If the answer is "No," describe in detail which of the employee's essential job function(s) is impacted by the condition and the way in which that job function is impacted. Include specific detail regarding the limitations the employee has with regard to the identified function (e.g., if limitations relate to standing, sitting, lifting, etc., please indicate in detail what the limits are).

If the answer to Number III.A. above is "No," can the employee perform the essential functions of the job **with** a reasonable accommodation?

☐ Yes ☐ No

If the answer is "Yes," please describe **<u>any and all accommodations</u>** that would enable the employee to perform the essential functions of his or her job. If you would recommend any one of these accommodations over another, please so indicate and explain why.

How long do you anticipate the employee needing accommodation to perform the essential functions of his or her job?

C. If you recommend that the employee be granted a leave of absence as a reasonable accommodation, will the granting of said leave enable the employee to return to work and perform the essential functions of the job as set forth in the attached job description?

☐ Yes ☐ No

If the answer is "Yes," what is the duration of the recommended leave?

D. Can the employee perform the essential functions of the job **with or without** accommodation without posing a direct threat to his safety or the health and safety of others in the work place? ☐ Yes ☐ No

III. Reevaluation:

A. When will the employee be reevaluated? ______________________

Signature: ______________________ **Date:** ______________________

Name (please print): ______________________

Address: ______________________

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Telephone: ______________________

Medical Specialty: ______________________

Date of Board Certification: ______________________