



# County of Sacramento

## Reasonable Accommodation for Employees

Americans with Disabilities Act (ADA) and  
California Fair Employment & Housing Act (FEHA)

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 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 those employees to perform the essential functions of their job. Reasonable Accommodation may include, but is not limited to: job duty modification, shift or schedule change, time off for medical care, modification to work area, or assistive devices or aids.

### **EMPLOYEE INSTRUCTIONS:**

1. Complete the Employee section of the Reasonable Accommodation Request 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.
  - Note that incomplete information **may cause a delay** in processing your request.
2. After completing the Employee section, **submit the entire packet** to your Health Care Provider and ask him/her to complete the Health Care Provider section.
3. Return all completed forms to the Sacramento County Disability Compliance Office (DCO).
  - US Mail: 700 H St., Room 5720, Sacramento CA 95814
  - Inter-Office Mail: 09-5720
  - FAX: (916) 874-7132
  - E-Mail: [dco@saccounty.gov](mailto:dco@saccounty.gov)
4. You will be notified in writing by the DCO whether your medical condition qualifies under the law, making you eligible for accommodation, and advised of next steps in the process.
5. Contact the DCO if you have questions: (916) 874-7642 voice, (916) 874-7647 TTY/TDD, or via the E-mail address above.

### **HEALTH CARE PROVIDER INSTRUCTIONS:**

1. Complete the Health Care Provider section of the Reasonable Accommodation Request form:
  - Type or print legibly and sign. Incomplete forms or illegible information may cause a delay in your patient/our employee receiving a Reasonable Accommodation.
  - DO NOT state a medical diagnosis.
  - 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.
2. Return completed forms either to your patient or to the Sacramento County Disability Compliance Office using the contact information above. **THANK YOU FOR YOUR COOPERATION!**

Revised December 2016



**County of Sacramento**  
**Reasonable Accommodation Request for Employees**  
**Americans with Disabilities Act (ADA) and**  
**California Fair Employment & Housing Act (FEHA)**

**EMPLOYEE to Complete:**

Date \_\_\_\_\_ Employee ID# \_\_\_\_\_  
 Name \_\_\_\_\_ Phone Contact \_\_\_\_\_  
 Job Title \_\_\_\_\_ E-Mail Contact \_\_\_\_\_  
 Supervisor Name \_\_\_\_\_ Dept./Agency \_\_\_\_\_

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 **If NO, please state its expected duration:**  
 \_\_\_\_\_

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

4. 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.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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  Not Sure

**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 in my FEHA medical file, which is separate from my personnel file. As part of my request for Reasonable Accommodation, I authorize:

- My Health Care Provider to disclose to the Disability Compliance Office any related medical restrictions/limitations of which they are aware.
- Workers' Compensation to disclose to the Disability Compliance Office any related medical restrictions/limitations, my current status, my treatment program and any job modifications which I have received.
- The Disability Compliance Office to provide a copy of my FEHA medical file to the Sacramento County Employee Retirement System (SCERS) upon my filing an application for Disability Retirement with them.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**HEALTH CARE PROVIDER to Complete:**

Patient/Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

- Yes       No

**If YES, please complete the following:**

2. Type of Impairment:

- Physical       Mental       Both

3. What major life activity is limited?

- |                                   |  |   |
|-----------------------------------|--|---|
| <input type="checkbox"/> Sitting  | <input type="checkbox"/> Standing                | <input type="checkbox"/> Lifting            |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Walking                 | <input type="checkbox"/> Breathing          |
| <input type="checkbox"/> Seeing   | <input type="checkbox"/> Hearing                 | <input type="checkbox"/> Sleeping           |
| <input type="checkbox"/> Thinking | <input type="checkbox"/> Interacting with others | <input type="checkbox"/> Communicating      |
| <input type="checkbox"/> Learning | <input type="checkbox"/> Concentrating           | <input type="checkbox"/> Caring for oneself |
| <input type="checkbox"/> Working  | <input type="checkbox"/> Other: _____            |   |

4. Is the condition permanent?  Yes       No **If NO, please state its expected duration:**

\_\_\_\_\_

5. Please state the patient/employee's specific health restrictions or limitations: (DO NOT STATE DIAGNOSIS)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Scheduled treatment:

\_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (printed) \_\_\_\_\_ Specialty: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

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, except as 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 member receiving assistive reproductive services. 29 C.F.R. §1635.8(b)(1)(i)(B).