Sacramento Employment and Training Agency
Reasonable Accommodation for Employees

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

In accordance with California's Fair Employment and Housing Act (FEHA) and the Americans with Disabilities Act (ADA), SETA 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 Human Resources Department.

- US Mail: 925 Del Paso Blvd., Suite 100, Sacramento CA 95815
- FAX: (916) 588-9176
- E-Mail: allison.noren@seta.net

4. You will be notified in by the Human Resources Department once the packet is received and advised of next steps in the process.

5. Contact the Human Resources Department if you have questions: (916) 263-3658 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 Human Resources Department using the contact information above.

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EMPLOYEE to Complete:

Date _____ Phone Contact _____

Name _____ E-mail Contact _____

Job Title _____ Department _____

Supervisor Name _____ Work Location _____

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 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 Human Resources Department any related medical restrictions/limitations of which they are aware.
- Workers' Compensation to disclose to the Human Resources Department any related medical restrictions/limitations, my current status, my treatment program and any job modifications which I have received.
- The Human Resources Department to provide a copy of my 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?

☐ Sitting	☐ Standing	☐ Lifting
☐ Reaching	☐ Walking	☐ Breathing
☐ Seeing	☐ Hearing	☐ Sleeping
☐ Thinking	☐ Interacting with others	☐ Communicating
☐ Learning	☐ Concentrating	☐ Caring for oneself
☐ Working	☐ 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).