Palomar Community College District
benefits@palomar.edu
Phone: 760.744.1150 X-2609

REQUEST FOR REASONABLE ACCOMMODATION

Employee Questionnaire

Please return completed form to Benefits Office, ST-1

Date	
Name	
Department	
Email address	
Position title	
Phone numbers (home, office and cell)	
Home address	
Supervisor's Name	

Please complete the following:

1. What, if any, position function are you having difficulty performing?

2. What, if any, employment benefit are you having difficulty accessing?

3. What limitation(s) is interfering with your ability to perform your job or access an employment benefit?

   Have you had any accommodations in the past for this same limitation? ☐ NO ☐ YES
   If *yes*, what were they and how effective were they?

4. Is there any additional information that you would like the Palomar Community College District to be aware of that may assist in this process. Please do not provide any information on your diagnosis, condition or treatment.

I certify that the above is true and accurate.

Employee's Original Signature Date

Received by:

Signed Print Name Date Received

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REQUEST FOR REASONABLE ACCOMMODATION

Physician Questionnaire

To: Employee's Personal Physician
From: Name, Title
Via: **Patient's Name:** _____
Re: Patient's Request For Reasonable Accommodation Medical Questinnaire

Your patient is in the process of requesting reasonable accommdoations from Palomar Community College District to assist him/her to perform the essential functions of his/her position safely. In compliance with the Fair Employment and Housing Act (Government Code § 12940) and Title I of the Americans with Disabilities Act (42 U.S.C. § 12101, et seq.), your assistance is requested to provide information in support of this request. Please answer the following questions and provide the completed questionnaire to your patient, who will return it, with her full application, to the Palomar Community College District Benefits Office for use in his/her interactive process.

As part of your evaluation of the questions below, please ensure that your patient has provided you with a copy of the information for his/her position:

Physician's Name: _____ **License Number:** _____

Physician's Phone Number: _____

Date of Examination: _____

I have reviewed the Position information for my patient, and can provide the following clarification:

(Check boxes and insert text as appropriate)

1. Does Your patient have a physical or mental impairment that limits his/her ability to engage in a major life activity, such as the ability to work, care for his/herself, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities. Pursuant to the FEHA amendments that went into effect on January 1, 2001, a condition can be said to "limit" one if the condition makes the achievement of the major life activity more difficult.

   ☐ NO, Your patient does not have a physical or mental impairment that limits his/her ability to engage in a major life activity.

   ☐ YES, Your patient has a ☐ PHYSICAL and/or ☐ MENTAL impairment that limits his/her ability to engage in a major life activity.

2. If the answer to question number one is yes, does the impairment currently affect your patient's ability to perform the essential functions of their position (see attached job description).

   ☐ NO, Your patient's impairment does not limit his/her ability to perform all of the essential functions of his/her position.

   ☐ YES, Your patient's impairment does affect his/her ability to perform the essential functions of their position.

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3. If the answer to question number two is yes, what work restriction(s) or functional limitations does his/her disability produce that are in need of accommodation? Please be as specific as possible. (e.g. if providing a restriction to standing, how many minutes can she stand before she would need to sit for X minutes, etc.) **List all necessary work restrictions with sufficient detail so all parties will understand how to interpret and apply them:**

☐ Restrictions are **TEMPORARY through _____ (date)** ☐ Restrictions are **PERMANENT**

Please mark all that apply:

☐ Maximum lifting/carrying of ____ pounds
☐ Maximum repetitive lifting/carrying of ____ pounds or more
☐ NO bending more than ____ times in a row and ____ minutes per hour
☐ NO twisting of the waist more than ____ minutes at one time and ____ minutes per hour
☐ NO stooping more than ____ minutes at one time and ____ minutes per hour
☐ NO squatting more than ____ minutes at one time and ____ minutes per
☐ NO kneeling more than ____ minutes at one time and ____ minutes per / ____ right ____ left ____ both knees
☐ NO pushing/pulling of ____ pounds of force
☐ NO standing in excess of ____ minutes at one time and ____ minutes per hour ____ hours per day
☐ NO sitting in excess of ____ minutes at one time and ____ minutes per hour ____ hours per day
☐ NO walking in excess of ____ minutes at one time and ____ minutes per hour ____ hours per day
☐ Restricted above shoulder level reach for ____ minutes at one time and ____ minutes per hour
☐ Must alternate sitting/standing after ____ minutes of one activity
☐ NO running or no running more than ____ minutes at one time and maximum minutes per day
☐ NO jumping
☐ NO climbing of stairs or steps or limit stairs and steps to ____ steps at one time
☐ Maximum keyboarding/data entry on one time ____ minutes, ____ minutes per hour and ____ hours per day
☐ Hand use limitations:

_____

☐ Neck motion limitations:

_____

☐ Other: (list below)

_____

_____

_____

_____

4. Does Your patient's continued assignment to their job pose a significant risk of substantial harm to the health and safety of the employee or others?

☐ NO ☐ YES, complete question # 5 and # 6 below.

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5. If the answer to question number four is yes, identify the duration, nature, severity, likelihood and imminence of each specific risk.

6. If the answer to question number four is yes, identify any specific work restrictions(s), that if accommodated, would reduce or eliminate the risk(s) described in question number five.

7. Additional Restrictions / Accommodation Suggestions / Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee.

Physician's Original Signature Date

Please return this completed form to your patient.