This form and any supporting materials or information is confidential and should be kept separate from an employee's personnel file.

SECTION A: TO BE COMPLETED BY EMPLOYEE

Name of Employee	Classification/Job Title
Work Location/Supervisor	Work Telephone Number/Email
Accommodation(s) Requested	
(Be as specific as possible, for example, adaptive equipment, reader, interpreter, training, schedule change, etc. Attach additional pages, if needed.)	
pages, if needed.)	
Is your limitation: Permanent Temporary Anticipated Recovery Date (if any)	u Unknown
Is the above described disability the subject of a worke	
Yes No If yes, date filed:	
Have you requested FMLA, CFRA, PDL or other leave in	n conjunction with the above described disability?
Yes No If yes, please specify what you	u requested and when:
I certify that I have a disability that requires reasonable above.	e accommodation, which will be met by the accommodation(s) listed
Signature of Employee	Date

SECTION B: CERTIFICATION FROM PHYSICIAN/HEALTH CARE PROVIDER

This employer is requesting a certification from a health care provider verifying that an accommodation is necessary. An employer may request this information when the employee's disability or need for accommodation is not apparent or known.

Attached is a list of the essential functions of	 (Employee Name)

For the job title:

Please provide a letter or verification addressing the following:

- 1. Verification that the employee has a disability (but not the diagnosis).
- 2. Description of how the employee's limitations impair the ability to perform the duties of the job (See attached list of essential functions).
 - a. Indicate whether these limitations are temporary or permanent.
 - b. If temporary, state when they are expected to end.
- 3. Recommendation of specific reasonable accommodation(s) that would allow the employee to perform the essential functions of the job.
 - a. If no accommodation is necessary, please indicate.

(Note: Use the space below or attach a letter or verification, which will be kept confidential. Employers must generally retain medical certifications and related documents separately from usual personnel files.)

Date Accommodation to Begin _			Date Accommodation to End or Continuous		
Name of Health Care Provider			- Return form to:		
Address			- Representative		
City	State	Zip Code	Company Name		
Telephone			Address		
Health Care Provider Signature			City	State	Zip Code
Cal Chamber。			© CalChamber	Pa	ge 2 of 5

1. Acknowledgment of Receipt of Reasonable Accommodation Request 2. Date Medical Documentation Received Date 3. Document all interactive discussions with employee, including dates of the discussions, employee's specific
2. Date Medical Documentation Received Date
3. Document all interactive discussions with employee, including dates of the discussions, employee's specific
request(s), names of all persons present, and what was discussed. Use additional pages, if required. Date Discussion Notes
4. List all potential reasonable accommodations identified in the interactive discussions.
5. List your recommended reasonable accommodations.
No employee medical information should be listed on this record. Any medical information should be kept in a separate, confidential medical file.

SECTION	D: TO BE COMPLETED BY EMPLOYER					
Status of	Request					
Accon	nmodation Granted on(date)					
Date	Accommodation to Begin					
Date	Date Accommodation to End (or Continuous)					
Date	Date Equipment Ordered If Needed and by Whom					
Date	Equipment Received by Employee					
List s	pecific accommodation(s) to be provided:					
Accon	nmodation Denied on(date)					
	ach accommodation requested by the employee that you deny, explain the reason for the denial (may k more than one box, use additional pages if needed):					
	Accommodation ineffective					
	Accommodation would cause undue hardship. Identify hardship:					
	Medical documentation inadequate					
	Accommodation would require removal of an essential job function. Identify function:					
	Accommodation would require lowering of performance or production standard. Identify standard:					
	No alternative vacant position available. Positions considered:					
	Employee rejected alternative accommodation. Identify accommodation offered and reason for employee's rejection:					
	Other (please identify)					
Further ex	xplanation/comments:					
Date	Signature					

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SECTION E: TO BE COMPLETED BY EMPLOYER FOLLOWING IMPLEMENTATION OF THE ACCOMMODATION(S)

Check in periodically with the employee to ensure that the accommodation is effective. If the accommodation is not effective, reengage in the interactive process.

Document all interactive discussions with employee, including dates of the discussions, names of all persons present, what was discussed and next step, if needed. Use additional pages if needed.

<u>Date</u>	Discussion Notes

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