COUNTY OF FRESNO *Leave of Absence Form*

ADA/FEHA ACCOMMODATION ***PHYSICIAN*** FORM

Patient Name:	**Patient DOB:**
Name and Title of person completing this form:	

A. Questions to help determine the employee's specific limitations*.

In order to qualify for a reasonable accommodation under applicable Federal and State law, an employee must have a physical or mental disability that limits one or more major life activities. The purpose of the following questions is to determine whether the employee has a physical or mental disability, and how the limitations created by the disability effect their ability to perform the essential functions of their job.

1. Does this employee have a physical or mental disability that limits a major life activity (including but not limited to caring for herself/himself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working)?

   ☐ Yes ☐ No (If NO, stop here, sign and date form.)

2. Is the limitation(s) caused by the disability permanent?

   ☐ Yes ☐ No

   If NOT permanent, what is the expected end date of the limitation(s)? _____

3. Is the employee undergoing treatment that you believe will allow them to return to usual and customary duties with or without a reasonable accommodation(s)?

   ☐ Yes ☐ No

   If "Yes", what is the expected return to work date? _____

4. Is the employee currently on medication that would interfere with their ability to safely perform their job functions?

   ☐ Yes ☐ No

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* 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.

B. Questions to help determine whether an accommodation is needed.

Please assess the employee's functional limitations and make a recommendation, if applicable, regarding reasonable accommodations that would allow the employee to return to work. The Essential Functions Inventory Form (EFIF) for the employee's job is attached for reference.

1. Please describe how the employee's functional limitations resulting from their disability will impact their ability to perform the essential functions of their job (see attached EFIF)? **EXAMPLE:** *"Jim can stand continuously for up to 60 minutes, with a 5 minute break between periods of continuous standing."*

2. Do you have any suggestions regarding possible accommodations that will enable the employee to perform the essential functions of his/her job, such as modification of equipment, workstation, etc.?

Health Care Provider's Name and Specialty (Please Print):	
Health Care Provider's Signature:	**Date:**
Address:	**Phone:**
City/State/Zip:	**Fax:**