

**REQUEST FOR CERTIFICATION UNDER CALIFORNIA FAIR EMPLOYMENT AND HOUSING ACT  
(FEHA) AND THE AMERICANS WITH DISABILITIES ACT (ADA)**

***PHYSICIAN/HEALTH CARE PROVIDER: IN ORDER FOR THE EMPLOYER TO BE ABLE TO PROPERLY EVALUATE THE INFORMATION PROVIDED, PLEASE ANSWER EACH AND EVERY QUESTION IN DETAIL.***

NOTE: 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 individuals’ 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.

Employee Name: \_\_\_\_\_

Date of Medical Evaluation: \_\_\_\_\_

**I. Certification of Qualifying Disability:**

A. **PHYSICAL DISABILITY:** Does the employee have a physiological disease, disorder, condition, cosmetic impairment or anatomical loss that:

1. Affects one or more of the body systems: neurological, immunological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin or endocrine?  
 Yes                       No

AND

2. Does this condition limit a major life activity<sup>1</sup>  
 Yes                       No

B. **MENTAL DISABILITY:**

1. Does the employee have any mental or psychological disorder or condition, such as cognitive disability, organic brain syndrome, emotional or mental illness, or specific learning disability?  
 Yes                       No

AND

2. Does this disorder or condition limit a major life activity<sup>1</sup>?  
 Yes                       No

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<sup>1</sup> Limits means that the condition makes the achievement of the life activity difficult. Such activities include physical, mental and social activities and working. They include functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. Primary attention is to be given to those life activities that affect employability, or otherwise present a barrier to employment or advancement.

- C. What is the duration of this condition, ( permanent or  temporary)? If temporary, for what period of time will the condition continue?

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**II. Limitation on Employee’s Abilities to Perform Essential Functions: In order to fully evaluate the potential accommodations that may be available for the employee, it is necessary that you complete in detail the following questions:**

- A. Review the attached job description.
- B. After reviewing the description, please indicate whether the employee can perform the essential functions of the position **without** reasonable accommodation.
- Yes             No

If the answer is “No,” describe in detail which of the employee’s essential job function(s) is impacted by the condition and the way in which that job function is impacted. Include specific detail regarding the limitations the employee has with regard to the identified function (e.g., if limitations relate to standing, sitting, lifting, etc., please indicate in detail what the limits are).

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(If more room is needed to describe the limitation, please feel free to attach additional sheets of paper)

If the answer to Number II.B above is “No,” can the employee perform the essential functions of the job **with** a reasonable accommodation?

- Yes             No

If the answer is “Yes,” please describe any and all accommodations that would enable the employee to perform the essential functions of his or her job. If you would recommend any one of these accommodations over another, please so indicate.

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How long do you anticipate the employee needing accommodation to perform the essential functions of his or her job?

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C. If you recommend that the employee be granted a leave of absence as a reasonable accommodation, will the granting of said leave enable the employee to return to work and perform the essential functions of the job as set forth in the attached job description?

Yes       No

If the answer is "Yes," what is the duration of the recommended leave?

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D. Can the employee perform the essential functions of the job **with or without** accommodation without posing a direct threat to his or her safety or the health and safety of others in the work place?

Yes       No

**III. Reevaluation:**

A. When will the employee be reevaluated?

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**HEALTHCARE PROVIDER INFORMATION: (REQUIRED)**

Name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Medical Specialty \_\_\_\_\_ Date of Board Certification \_\_\_\_\_

**EMPLOYEE INFORMATION: (REQUIRED TO BE FILLED OUT BY EMPLOYEE)**

Work Phone Number: \_\_\_\_\_ Work Email: \_\_\_\_\_

Direct Supervisor/Dept.: \_\_\_\_\_