



## MEMORANDUM

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**TO:** [Insert Name of Applicant]

**FROM:** [Insert Name of First-Level Manager]

**DATE:** [date sent]

**RE: Request for an Accommodation Based on a Disability**

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It is the policy of Peralta Community College District to provide equal employment opportunities to qualified individuals with disabilities consistent with its obligations under the Americans with Disabilities Act (ADA) and the Fair Employment and Housing Act (FEHA). When an applicant, such as you, requests reasonable accommodation, the District requires documentation of your need for, and entitlement to, reasonable accommodation. Documentation may be required concerning both your status as an individual with a disability and your functional limitations.

**Part A** of this form is to be completed by the applicant requesting an accommodation and returned to me. Please state the nature of your disability and what form of reasonable accommodation you are requesting so the District can assess whether you are a qualified individual with a disability as defined under the ADA and FEHA and then determine the District's obligation to provide you with an accommodation.

**Part B** of this form is to be completed by your attending physician after he or she has had an opportunity to review your job description. (Please include a copy of your position description with Part B for your attending physician.) The information contained in part B will enable the District to evaluate your request for reasonable accommodation.

The District's requirement that you submit information pertaining to your request for reasonable accommodation on this form should not be construed as a guarantee or promise on the part of the District to accommodate your particular request. Even if you are able to show that you are a qualified individual with a disability as defined under the ADA and FEHA, the District is not obligated to provide the particular form of accommodation that you request nor provide any form of accommodation that would be unreasonable or impose an undue hardship on the District.

Attachments



## Part A: To be completed by the Applicant

I. Applicant's Name: \_\_\_\_\_  
Last First Middle

II. Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

III. Nature of Your Disability and Form of Reasonable Accommodation You Are Requesting

a) Describe the nature of your disability to the extent that you feel that it limits your ability to perform the essential functions of your job.

b) What form of reasonable accommodation(s) are you requesting?

c) If you are requesting that the District provide equipment or devices to accommodate your disability, it would be helpful if you could provide vendors' quotations on the type and cost of any equipment or device you are requesting here.

IV. Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **Part B: To be completed by health care provider (sign and return to applicant)**

Name of Applicant \_\_\_\_\_

The applicant named on this form has requested reasonable accommodation of his or her disability. The purpose of this evaluation is to enable the employer to assess the applicant's functional limitations and what, if any, reasonable accommodations should be made.

As defined under the Americans with Disabilities Act and the Fair Employment and Housing Act, a qualified individual with a disability is a person who satisfies the requisite skill, experience, education and other job-related requirements of the position, and who with or without reasonable accommodation, can perform the essential functions of the job. Such an individual must be able to demonstrate: 1) a physical or mental impairment that limits one or more major life activities; 2) a record of such an impairment; or 3) is regarded as having such an impairment.

In order for an impairment to be considered limiting, the individual must be restricted in the ability to perform a job as compared to the average person having comparable training, skills, and abilities.

The following factors should be considered in determining whether an individual is limited in his or her ability to work:

- 1) the nature and severity of the impairment;
- 2) the duration or expected duration of the impairment; and
- 3) the permanent or long term impact, or the expected permanent or long-term impact of or resulting from the impairment.

**[NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS OR STATEMENT OF MEDICAL CAUSE WITHOUT THE CONSENT OF THE PATIENT. SEE ATTACHED AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION.]**

- I.** Does the applicant's condition meet the criteria for disability described above?
- a) Is the applicant able to perform work of any kind?
  - b) Please describe nature and severity of the impairment as it relates to the ability of the applicant to interview and perform the essential functions of his or her job. (Review applicant's job description, or if none provided, interview applicant about job tasks.)
  - c) Does the applicant's impairment substantially limit his or her ability to perform one or more of the essential functions of his or her job? Which ones? In what way?



## Part B: continued

- II.** What, if any, form(s) of reasonable accommodation would enable the applicant to perform the essential functions of his or her job?
- III.** If the applicant has sought treatment for his or her disability, what is the date that the disability or need for treatment commenced?
- IV.** What is the expected duration of disability (if temporary, please give a date on which the applicant may return to full duty and if permanent, please so state)?
- V.** If it is medically necessary for the applicant to be off from work, either for a period of time, intermittently, or on a reduced-hours basis, describe schedule of treatment for applicant. Include duration of treatment and number of visits required with you or another health care provider to whom you are referring the applicant.

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_  
*(Attending Physician)*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Telephone Number:*

\_\_\_\_\_  
*Address*



## Authorization for Release of Medical Information

I, \_\_\_\_\_, (*Name of Applicant*), hereby authorize \_\_\_\_\_, (*Name of attending physician*), to release to my employer, Peralta Community College District, medical information that will enable the District to evaluate my status as a qualified individual with a disability and my request for reasonable accommodation under the Americans with Disabilities Act and Fair Employment and Housing Act (FEHA). I understand that I am authorizing the disclosure of medical information which may describe my functional limitations that may entitle me to leave from work for medical reasons or limit my fitness to perform my present job, provided that no statement of medical cause is included in the information disclosed as consistent with the Confidentiality of Medical Information Act, Civil Code Section 56.10.

This authorization is valid until revoked in writing by me.

I have been advised of my right to receive a copy of this authorization. A photocopy shall be considered as valid as the original.

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_  
(*Signature of Applicant*)