



Health Care Provider Certification for Reasonable Accommodation Request (Employee or Applicant)

To be completed by employee/applicant: [Please print or type]

Name: _____

Position: _____

To be completed by health care provider: [Please print or type]

The medical information below is requested by the Contra Costa Community College District so that the District may evaluate a request for reasonable accommodation made by the above employee/applicant under the Americans with Disabilities Act (ADA), the California Fair Employment and Housing Act (FEHA), and related state and federal laws. The District seeks information to help it determine whether the employee/applicant has a "protected disability" and the nature and extent of the employee/applicant's "functional limitations" as they relate to performing the essential functions of the position. Under the law, a "disability" is defined as "a physical or mental impairment which limits one or more major life activities." Examples of major life activities include performing manual tasks, walking, seeing, hearing, speaking, learning, and working.

1. Does employee/applicant have a physical or mental impairment which in your opinion limits one or more major life activities? Yes No *(Do not state the medical cause/diagnosis of the impairment.)*

2. What is the probable duration of the impairment?

3. What functional limitations does the impairment place on the employee/applicant's ability to perform the essential job functions of the position or on the applicant's ability to complete the job application and selection process? *(See attached job description or other information. Attach additional sheets if necessary.)* Please be specific. Do not include proposed accommodations *(those will be listed below)*. This should specify what duties the employee/applicant is unable to perform or has difficulty performing or which parts of the application and hiring process preclude the disabled applicant from having equal opportunity to be considered for the job.

4. In your opinion, would the employment of the above person in the position or would allowing the above person to participate in the application and hiring process with reasonable accommodation pose a significant risk of harm to himself/herself or other persons? Yes No



Health Care Provider Certification for Reasonable Accommodation Request (Employee or Applicant)

5. If your answer to number 4 is "Yes," what is the specific risk involved?

The duration of the risk? The nature and severity of the potential harm? The likelihood that the potential harm will occur? The imminence of the potential harm? What reasonable accommodations, if any, could eliminate the risk or reduce it to an acceptable level?

6. Please state any suggestions you may have as to how the employee/applicant can perform the essential job functions of position with accommodations provided by the District or how the applicant can complete the job application and selection process with accommodations? (*Attach additional sheets if necessary.*)

Health Care Provider Name and Title: (Print)

Name: _____

Title: _____

Licensing and Specialty (Print):

Business Address/Telephone Number:

Signature: _____

Date: _____