FRESNO STATE
Discovery. Diversity. Distinction.

REQUEST FOR REASONABLE ACCOMMODATION-CONFIDENTIAL

The California Fair Employment and Housing Act requires employers of five or more employees to provide reasonable accommodation for individuals with a physical or mental disability to perform the essential functions of their job unless it would cause an undue hardship. The law does not require the use of this or any other form to make a request for a reasonable accommodation. This form and any supporting materials or information is confidential and should be kept separate from an employee's personnel file.

☐ Request for sit to stand ☐ COVID-19 Related (Temporary Accommodation

☐ Other

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.):

REASON FOR REQUEST (Please do not disclose your diagnosis; explain your disability-related limitations and how this accommodation will help you do your job.)

IS YOUR LIMITATION: ☐ Permanent ☐ Temporary ☑ Unknown	ANTICIPATED RECOVERY DATE (if any)

IS THE ABOVE DESCRIBED DISABILITY THE SUBJECT OF A WORKER'S COMPENSATION CLAIM? (Employees with work related injuries may also be eligible for a reasonable accommodation independent of the worker's compensation process.)
☐ YES ☐ NO IF YES, DATE FILED:

HAVE YOU REQUESTED FMLA, CFRA, PDL, OR OTHER LEAVE IN CONNECTION WITH THE ABOVE DESCRIBED DISABILITY?
☐ YES ☐ NO IF YES, PLEASE SPECIFY WHAT YOU REQUESTED AND WHEN:

I CERTIFY THAT I HAVE A DISABILITY THAT REQUIRES REASONABLE ACCOMMODATION, WHICH WILL BE MET BY THE ACCOMMODATION(S) LISTED ABOVE.

SIGNATURE OF EMPLOYEE **DATE**

SECTION B:

CERTIFICATION FROM PHYSICIAN/HEALTH CARE PROVIDER:

When an employee's disability or need for accommodation is not apparent or known to the employer, the employer may request a certification from a health care provider verifying that an accommodation is necessary. The employer should provide the employee with a copy of a job duty statement to share with the health care provider.

For completion by the health care provider: 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 and indication of whether these limitations are temporary or permanent.
    a. If temporary, state when they are expected to end.
3. Recommendation of specific reasonable accommodation(s).

(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	SIGNATURE OF HEALTH CARE PROVIDER

Return completed form to Human Resources via FAX 559-278-4275 or U.S. mail to: Human Resources, ATTN: ADA Manager, 5150 N Maple Avenue, M/S JA 41, Fresno, CA 93740.