CALIFORNIA STATE UNIVERSITY
Stanislaus

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.

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

Note: Once completed, this form may be either returned to the employee or scanned/faxed as addressed below. The employee may choose either.

California State University, Stanislaus
Human Resources
Attn: Christina Knott, Employee/Labor Relations, Leaves & Compliance Manager
Email: cknott@csustan.edu; Fax: 209-664-7011

SECTION C: INTERACTIVE PROCESS DISCUSSION TO BE COMPLETED BY EMPLOYER

1. Document all interactive discussions with employee, including dates of the discussions, employee's specific request(s), names of all persons present, and what was discussed. Use additional pages if required.

Date	Discussion Notes
_____	
_____	
_____	
_____	

2. List all potential reasonable accommodations identified in the interactive discussions and the strengths and weaknesses for each as a potential reasonable accommodation.

3. State your recommended reasonable accommodation and the rationale for your recommendation.

SECTION D: TO BE COMPLETED BY EMPLOYER

LIST SPECIFIC ACCOMMODATION(S) TO BE PROVIDED:

For each accommodation requested by the employee that you deny, explain the reason for the denial: (may check more than one box, use additional pages if needed)

☐ Accommodation Ineffective
☐ Accommodation Would Cause Undue Hardship. Identify Hardship: _____
☐ Medical Documentation Inadequate
☐ Accommodation Would Require Removal of an Essential Job Function. Identify Function: _____
☐ Accommodation Would Require Lowering of Performance or Production Standard. Identify Standard: _____
☐ No Alternative Vacant Position Available. Positions Considered: _____
☐ Employee Rejected Alternative Accommodation. Identify Accommodation Offered and Reason for Employee's Rejection:
☐ Other (Please identify) _____

Further Explanation/Comments:

_____ _____

Date Signature

	DATES
ACKNOWLEDGEMENT OF RECEIPT OF REASONABLE ACCOMMODATION REQUEST	
DATE ACCOMMODATION TO BEGIN	
DATE ACCOMMODATION TO END	
DATE EQUIPMENT ORDERED IF NEEDED AND BY WHOM	
DATE EQUIPMENT WAS RECEIVED BY EMPLOYEE	

SECTION E: TO BE COMPLETED BY EMPLOYER FOLLOWING IMPLEMENTATION OF THE ACCOMMODATION(S)

The employer should check in periodically with the employee to ensure that the accommodation is effective. If the accommodation is not effective, there is a duty to reengage in the interactive process.

Document all interactive discussions with employee, including dates of the discussions, names of all persons present, what was discussed, and next steps if needed. Use additional pages if needed.

Date	Discussion Notes
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