

REASONABLE ACCOMMODATION REQUEST

SO-142 (Rev. 02/17)

The information requested below is confidential and will only be used to determine the specific equipment and/or services necessary to accommodate your work-related limitations due to disability or medical condition that can be verified. You or your representative should provide the following information. Determination on a request cannot be made if the request is incomplete.

CONFIDENTIAL

This document contains personal information, and pursuant to Civil Code 1798.21, it shall be kept confidential in order to protect against unauthorized disclosure.

NAME	BUSINESS PHONE ()
JOB CLASSIFICATION	HOME PHONE ()
DIVISION/BRANCH/UNIT	E-MAIL ADDRESS
NAME OF SUPERVISOR	BUSINESS PHONE ()

SECTION I. REQUEST FOR REASONABLE ACCOMMODATION

A reasonable accommodation is a modification or adjustment to a job and/or work environment which enables a qualified individual with a disability to perform the essential functions of his/her position, and allows a person with a disability to take part in any and all aspects of the employment process. In order for the Department to make a determination on your request, the following information is required. *The request will be considered incomplete if all information is not provided. A determination cannot be made on an incomplete request.* Attach additional sheets of paper if necessary.

1. I have a disability or medical condition that requires a:

- Permanent reasonable accommodation.
 Temporary reasonable accommodation.

What is the expected duration of the temporary disability? _____

2. Describe how your disability or medical condition limits your ability to perform the essential functions of your job or otherwise receive treatment equal to that provided to other employees. **ATTACH YOUR DUTY STATEMENT.**

3. Provide a description of the accommodation requested. If applicable, please include the name of vendor(s), approximate costs and availability of goods/services requested, if known.

4. Explain how the requested accommodation will assist you in performing the essential functions of your job or provide you the same opportunities available to other employees.

EMPLOYEE CERTIFICATION

I certify that I have a disability or medical condition that requires reasonable accommodation, which will be met by acquiring the work adjustments, equipment, or services described above.

Employee Signature

Date

Home Address

City, State, Zip

Home Telephone Number (please include area code)

SECTION II. MEDICAL VERIFICATION FROM ATTENDING HEALTH PROFESSIONAL

This request must include the attending health professional's verification that meets the following criteria. If the attending health professional's verification is not attached or does not meet the following criteria, the Department must obtain the information from the attending health professional before the request is considered complete and a determination can be made.

- a. Documentation must provide evidence of disability that includes a medical recommendation for reasonable accommodation.
- b. The documentation must be written on the official letterhead of the qualified health professional or health professional's organization and contain the name of the treating health professional. (Note: Acceptable treating physicians are doctor of medicine (M.D.), Chiropractic (D.C.), Osteopathic (D.O.), Podiatry (D.P.M.) or Psychology (Ph.D.).)
- c. The document must be dated and signed by the health professional.
- d. The limitations caused by the disability or condition must be described in detail as they currently exist and only in relationship to the job, and whether the disability is permanent or temporary. If temporary, the date the disability is expected to end must be specified.
- e. The documentation must explain how the accommodation will permit the employee to perform the essential functions of the job.
- f. If it is recommended that an item be purchased, indicate where it may be obtained and include cost and model number. If it is recommended that the work site be modified, or specific duties be restructured or shared, describe the necessary action.

If information received is insufficient for making a determination, additional information may be required from the attending health professional.

**AUTHORIZATION FOR THE RELEASE OF
MEDICAL INFORMATION**

To: Health Professional's Name: _____

Address: _____

Telephone: _____

In order to assist in a determination of my reasonable accommodation request submitted to the California Department of Food and Agriculture, I authorize you to release to the California Department of Food and Agriculture, Equal Employment Opportunity Office, 1220 N Street, Room 233, Sacramento, California 95814, information concerning my physical or mental health with regard to my request for reasonable accommodation.

This authorization shall be valid for a period of 90-days after the date of my signature or earlier if revoked by me in writing to the California Department of Food and Agriculture. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization upon request.

✓ _____ ✓ _____
Employee Signature Date

SECTION III. RECEIPT OF REASONABLE ACCOMMODATION REQUEST

Signature below indicates that the manager or supervisor of the employee requesting a reasonable accommodation has been provided the completed reasonable accommodation request.

✓ _____ ✓
Supervisor's Signature Date Signed

The manager or supervisor must provide the employee with a signed copy of the completed request and forward the request to the EEO Office.

If the reasonable accommodation request is denied, or if the Department has not responded within 20 working days of the receipt of a completed request, the employee may file an appeal with:

**State Personnel Board
Appeals Division
801 Capitol Mall, MS #22
Sacramento, CA 95814
FAX: (916) 654-6055
Online: <https://appeals.spb.ca.gov/aos/appeal.html>
Email: appeals@spb.ca.gov**

Employees have the right to concurrently appeal to the Department of Fair Employment and Housing and/or the Equal Employment Opportunity Commission.

REASONABLE ACCOMMODATION (RA) REQUEST CHECKLIST

Make sure your request is complete. This checklist is for your use to ensure a complete request is submitted. RA requests will be considered incomplete if all information is not provided and will result in a delay and/or denial of the request. It is not necessary to submit this checklist with your request.

Did you remember to:

- Indicate whether your accommodation request is for a permanent or temporary accommodation?
- Indicate the expected duration of a temporary accommodation?
- Describe how your disability or condition limits your ability to perform the essential functions of your job?
- Attach your duty statement?
- Describe the requested accommodation?
- Explain how the requested accommodation will allow you to perform the essential functions of your job?
- Sign the employee certification and include your home address and telephone number?
- Attach your attending health professional's verification that meets the criteria listed (please see page 2 for criteria)?
- Sign the authorization for release of medical information?