UC SANTA BARBARA
Human Resources
**Workplace Accommodation Services**

**REQUEST FOR REASONABLE ACCOMMODATION**

# MEDICAL CERTIFICATION

## PART II: TO BE COMPLETED BY HEALTHCARE PROVIDER

**EMPLOYEE NAME:** _____ **EMPLOYEE #:** _____

**PHYSICIAN / MEDICAL PROVIDER: PLEASE DO NOT INDICATE DIAGNOSTIC INFORMATION.**

The Americans with Disabilities Act (ADA) and the Fair Employment & Housing Act (FEHA), describe a disability as a physical or mental impairment that substantially limits one or more major life function(s).

1) Does the employee have a disability? ☐ Yes ☐ No (if 'No', please sign and return)

2) If 'Yes', how long will the disability last? ☐ Ongoing/Permanent ☐ Temporary, until: _____ (date)

3) What are the employee's specific work restrictions and/or functional limitations? _____

_____

_____

4) How long will these work restrictions be in place?

☐ Temporary Restrictions- Anticipated End Date: _____ ☐ Permanent Restrictions

5) What job function(s) is the employee having trouble performing because of the limitation(s)?

_____

_____

_____

6) Do you have any suggestions as to possible accommodations?
***Note: If intermittent time off may be required for medical appointments or periods of incapacity, please specify <u>frequency</u> and <u>duration</u> of time off (ex: 2x/month; up to 2 hours/occurrence).***

_____

_____

_____

_____ _____
Physician / Medical Provider's Signature (Specify professional designation- ex: MD) Print Name

_____ _____
Date Address or Stamp

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**EMAIL OR FAX COMPLETED FORM TO UCSB, HR- WORKPLACE ACCOMMODATION**

**Email: workplaceaccommodations@hr.ucsb.edu • Fax: (805) 893-8645**