The Office of Human Resources · 333 S. Twin Oaks Valley Road · San Marcos, CA 92096-0001 · (760)750-4418 · Secure Fax (833)536-1793 · workplaceaccommodation@csusm.edu

Physician/Health Care Provider: The information requested below is being sought in order to fully understand and evaluate an employee's request for employment accommodation related to an ADA-qualified disability. Please answer each and every question.

Pursuant to Title II of the Genetic Nondiscrimination Act of 2008 (GINA), do 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. This form is to request information pertaining to the Americans with Disabilities Act, as Amended of 2008, (ADAAA) and California's Fair Employment and Housing Act (FEHA).

Employee Name:_____

Date of Medical Evaluation:_____

Length of time this individual has been under your care:_____

Does the individual listed above have a physical or mental disability or medical condition that limits a major life activity?

☐ Yes - Proceed with questions.

☐ No - Do not proceed with questions. Complete contact information at the end of this form and submit to Human Resources.

What major life activities do you believe are limited by the impairment? Please check the level of limitation you believe the employee experiences as a result of their impairment. Check only the boxes that apply.

1 = Unable to determine 2 = Mild 3 = Severe

Major Life Activity	1	2	3
Caring for Oneself			
Performing manual tasks			
Seeing			
Hearing			
Eating			
Sleeping			
Breathing			
Operation of major bodily functions:			

Major Life Activity	1	2	3
Learning			
Reading			
Concentrating			
Thinking			
Speaking			
Written Communication			
Interacting with others			
Working			

Major Life Activity	1	2	3
Standing			
Walking			
Sitting			
Reaching			
Bending			
Lifting>_ lbs.			
Other (please specify):			

2. Describe the employee's current functional limitations as a result of the impairment (e.g., cannot type or do data entry):

_____

_____

3. Details about the impairment:

a) What is the duration of the impairment?_____
(e.g. temporary, long-term, permanent)

b) If not permanent, how long will the impairment likely last? _____
(e.g.approximate number of weeks, months or years)

c) If impairment is episodic, please state frequency of flare ups. _____
(e.g.approximate no. per week, month, or year)

Is it medically necessary for the employee to be absent from work during episodic flare-ups? ☐ Yes - explain below ☐ No

_____

_____

4. In order to answer the next questions, you must review the employee's written position description, which they are required to provide to you (except for faculty employees-formal position descriptions don't exist for faculty so please discuss with them the essential functions of their jobs). Have you reviewed the employee's written position description or, in the case of a faculty member, discussed their position's essential functions? ☐ Yes ☐ No

Accommodation – An accommodation is any adjustment to a work environment or job that allows an employee to perform the essential functions of the job in question.

5. After reviewing the position description, please indicate whether the employee can perform the essential functions of the position **without** accommodation.

☐ Yes, the employee can perform the essential functions of their position without accommodation.

☐ No, the employee cannot perform the essential functions of their position without accommodation.

If the answer is NO, describe in detail which of the employee's essential job functions are impacted by the impairment/condition and the way in which that job function is impacted. (E.g., if the impairment is that the employee cannot type, the employee may be unable to respond to email or do data entry.)

_____

_____

6. If the employee cannot perform the essential functions of their job **without** accommodations, can the employee perform the essential functions of the job **with** accommodation? ☐ Yes ☐ No

a) If the answer is YES, please describe <u>any and all</u> accommodations, to the best of your knowledge, that would enable the employee to perform the essential functions of their job. For instance, in the example above, an accommodation might be to provide the employee with dictation software.

_____

_____

b) If the employee requires medical leave as an accommodation, would providing the requested amount of leave assist the employee to return to work and perform their essential job duties? What is the duration of the medical leave?

_____

_____

7. How long do you anticipate the employee needing accommodation to perform the essential functions of their job?_____

8. In the absence of workplace accommodation(s), while performing their job duties would the employee pose a direct threat to their safety or health, and/or to the safety of others in the workplace? ☐ Yes ☐ No

*If YES, please explain the substantial harm and significant risk this may impose on the employee or others.

_____

_____

9. Reevaluation: When will the employee be medically reevaluated?

_____

For COVID-19 related disability accommodation requests, please also answer these questions:

1. Is the employee fully vaccinated for COVID-19? ☐ Yes ☐ No
2. Does the employee have any of the following conditions? ☐ Yes ☐ No
   - Has been receiving active cancer treatment for tumors or cancers of the blood
   - Received an organ transplant and are taking medicine to suppress the immune system
   - Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
   - Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
   - Advanced or untreated HIV infection
   - Active treatment with high-dose corticosteroids or other drugs that may suppress their immune response
3. I am aware that CSU San Marcos and the CSU have a COVID-vaccine mandate (https://calstate.policystat.com/policy/9779821/latest/) for all students and employees who plan to access campus or participate in CSUSM programs. Vaccination rates are above 90% for the campus and unvaccinated individuals must submit to regular surveillance testing. ☐ Yes ☐ No
4. Would the employee be able to work on campus with any of the following non-pharmaceutical interventions: Personal Protective Equipment (PPE), coworkers and/or students wearing PPE, plexi-glass, physical distancing, enhanced office ventilation, and/or a private office. ☐ Yes ☐ No

   If the answer is yes, please identify which of the above interventions you recommend:

   _____

   _____

   If the answer is no, please explain why.

   _____

   _____

Certifying Licensed Physician or Primary Health Care Professional in Appropriate Specialty

Name: _____ Medical Facility: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip: _____

License Number: _____ Date of Board Certification: _____ Medical Specialty: _____

Signature: _____ Date: _____

I hereby certify that the information contained herein is true and accurate to the best of my knowledge