MADERA UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT

PART I: To be completed by the employee.

REQUEST FOR JOB ACCOMMODATION FORM

Employee Name_____ Work Location_____

Job Title _____ Full-time ☐ Part-time ☐

1. Please indicate the accommodation(s) being requested. Be as specific as possible.

_____
_____
_____
_____
_____
_____

2. Please indicate the reason for an accommodation. Explain your disability-related limitations and how this accommodation will help you do your job. **Do not disclose your medical condition.**

_____
_____
_____
_____
_____
_____

3. Is your limitation ☐ Permanent ☐ Temporary ☐ Unknown

4. Anticipated Recovery Date (if any): _____

5. Is the above described disability the subject of a worker's compensation claim? ☐ Yes ☐ No

6. Have you requested FMLA, CFRA or other leave in connection with the above described disability?
☐ Yes ☐ No If yes, please specify the type of leave and when:_____
_____
_____

Employee Signature:_____ Date:_____

MADERA UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT

PART II: To be completed by the treating physician

MEDICAL CERTIFICATION FORM

_____ is requesting a job accommodation based on a qualifying disability. After reviewing the job description of the employee's position (see attached), please examine the employee and provide your medical opinion on questions 1-5 below to assist us in determining a reasonable accommodation.

1. In your opinion, does the employee have a physical or mental impairment that limits one or more of the major life activities that includes physical, mental and social activities and working? ☐ Yes ☐ No

   If "No", please skip questions 2, 3, 4. When done, complete the signature box on page 3 of this form.

   If "Yes", please describe how the employee's limitations impair the ability to perform the duties of the job. ***Do not include a diagnosis.***

   _____

   _____

2. In your opinion, after examining the employee and reviewing the job description, is a job modification or accommodation necessary to enable the employee to perform the essential functions of the position? ☐ Yes ☐ No

   If yes, please describe your suggested modification(s) or accommodation(s):

   _____

   _____

   Please include the frequency and duration of each restriction (e.g., "typing a maximum of 4 hours per day in 50-minute intervals per hour to expire 11/12/04") and attach any additional restrictions or information not covered below.

   If it is recommended for the employee to **work from home**, is the employee completely isolated and unable to leave the home for any reason? ☐ Yes If, yes, please describe below. ☐ No

Medical Limitations/Restrictions	Frequency	Beginning and Ending Date

3. Are the limitations ☐ Permanent or ☐ Temporary? If temporary, please indicate a date when the limitations are expected to end. _____

4. A job accommodation is expected to allow the employee to perform the essential functions of the job at 100%. In your opinion, are there any functions of the position, as described in the attached job description, that the Employee ***cannot*** perform, either with or without an accommodation?
   ☐ Yes ☐ No

   If "Yes", which function(s) or percentage (%) is the employee unable to perform either with or without an accommodation?

   _____

   _____

HEALTH CARE PROVIDER SIGNATURE BOX
Name of treating physician: _____ (Print) Signature of treating physician: _____ Name of Medical Group: _____ Address/Phone Number: _____ Date completed: _____

Part I and Part II must be completed in full then signed and submitted to the employer no later than_____.

The information received from the Health Care provider will be treated as confidential medical information.

- Part I - *Request for Job Accommodation Form*
- Part II – *Medical Certification Form*

Please submit documents to:

Madera Unified School District
Human Resources Department
1902 Howard Road
Madera, Ca. 93637
Attn: Human Resource Officer
Fax: (559) 673-6016