The California Department of General Services (DGS) does not discriminate on the basis of disability in its hiring or employment practices, nor does it retaliate against individuals who participate in the reasonable accommodation process. DGS will not deny anyone a job-related opportunity based on an individual's request for a reasonable accommodation. DGS will use the definition for mental and physical disability set forth in the California Fair Employment and Housing Act (Gov. Code, § 12926) unless the definitions under the federal Americans with Disabilities Act would provide greater protection.

To request reasonable accommodation, an employee or an applicant needs to communicate their needs verbally, in writing, or in a manner that can be understood by the supervisor, manager, or authorized personnel for the purpose of providing reasonable accommodation. To expedite the interactive process, employees and applicants are encouraged to use this reasonable accommodation form to ensure all necessary information is obtained.

Instructions for employee/applicant:

Section A Provide your identifying information, list requested accommodation, reason for requested accommodation, and list the duration the accommodation will be needed.

Section B If requested, have your healthcare provider answer questions 1 – 8, date, sign, and provide his/her credentials and health organization in the appropriate areas. Be sure to provide your healthcare provider a copy of your duty statement or examination bulletin. Once all parts have been completed, sign and date the form and give it to your supervisor or the Reasonable Accommodation Coordinator (RAC). It is the employee and applicant's responsibility to ensure they respond to DGS' requests for further information related to the request for reasonable accommodation. The employee or applicant also incurs all costs associated in providing this information to DGS.

The Genetic Information Nondiscrimination Act (GINA) prohibits employers 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 do not provide any genetic information when responding to requests 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.

Instructions for Supervisor:

As soon as possible, but no more than five (5) working days after becoming aware of the individuals need for reasonable accommodation, communicate and forward any documentation pertaining to the request to the RAC at ReasonableAccommodation@dgs.ca.gov. If the individual's request for accommodation is made verbally, please use this form to document the request and ask the individual to verify the information and sign the request to ensure the information is accurate. If the individual does not, or cannot, sign the request, the supervisor should note the employee did not, or could not sign, and forward the request to the RAC.

The Department of General Services (DGS) provides reasonable accommodation for employees and job applicants with a qualified medical condition or disability, 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 reasonable accommodation. Medical certification may be required (see Section B).

SECTION A: TO BE COMPLETED BY EMPLOYEE/APPLICANT		
Last Name:	First Name:	Middle Initial:
Classification:	Email Address:	Phone Number:
Supervisor Name:	Supervisor Phone Number:	
Program (Office/Division/Unit):		

Is this request for a lactation accommodation? ☐ Yes ☐ No	Is this request related to a workers' compensation claim? ☐ Yes ☐ No	Have you requested FMLA, CFRA, or PDL leave protections? ☐ Yes ☐ No

Accommodation(s) Requested:
Be as specific as possible, for example, adaptive equipment, reader, interpreter, training, schedule change, etc.

Reason for Request:
Do not disclose your diagnosis; explain your medical and/or disability-related limitations and how this accommodation will allow you to perform the essential functions of your position.

Is your limitation: ☐ Permanent ☐ Temporary ☐ Unknown	Anticipated Recovery Date (if applicable):

By signing, I certify that I have a qualified medical condition or disability that requires reasonable accommodation(s), which will be met by the accommodation(s) listed above.

Employee/Applicant Signature: _____ Date: _____

SECTION B: TO BE COMPLETED BY HEALTHCARE PROVIDER		
DGS may request certification from a healthcare provider verifying that an accommodation is necessary. The employee requesting an accommodation should provide their healthcare provider a copy of their current duty statement to determine what accommodations may be necessary. **Do not disclose the diagnosis on this form.**		
1. Patient's Name:		
2. Does the patient have a qualified medical condition or disability which limits one or more major life activities and makes the employee unable to perform any essential functions of their position (see duty statement)? 3. ☐ Yes ☐ No		
4. Patient's limitations are: ☐ Permanent **OR** ☐ Temporary: If temporary, anticipated recovery date: _____		
5. Is it medically necessary that the employee have a work-related accommodation (or medically advisable if related to pregnancy)? ☐ Yes ☐ No		
6. If yes, describe the essential function(s) the patient is not able to perform:		
7. Describe detailed and specific limitations that prevent the patient from performing the essential function(s) of their position (e.g., unable to type continuously for more than 30 minutes, unable to lift more than 20 pounds, etc.):		
8. Identify recommendations for specific accommodations which will help the patient overcome their limitations. If recommending equipment, include the cost, model number and where it may be obtained, if possible:		
Date Accommodation to Begin:	Date Accommodation to End:	
Provider Last Name:	Provider First Name:	Provider Credentials:
Health Care Organization Name:	I certify that I have reviewed the patient's duty statement: ☐ Yes ☐ No	
Provider Signature:	Date:	

SECTION B: TO BE COMPLETED BY HEALTHCARE PROVIDER (Continued)

Medical certification may alternatively be submitted by letter to the Office of Human Resources (OHR) and must include all of the following:

1. On official letterhead of the qualified healthcare provider or healthcare providers organization.
2. Certification that the patient has a qualified medical condition or disability (do not include diagnosis).
3. Indication of whether limitations are permanent or temporary.
   a. If temporary, provide anticipated recovery date.
4. Description of how the patient's limitation impairs their ability to perform the essential functions of their position (see duty statement).
5. Patient's limitations must be described in detail as they currently exist and only in relationship to the essential functions of the position.
   Examples:
   - Unable to type continuously for more than 30 minutes.
   - Unable to lift more than 20 pounds.
6. Recommendation of specific accommodation(s).
7. Certification that recommended accommodation is medically necessary, or medically advisable when related to pregnancy.
8. If it is recommended that equipment be purchased, include the cost, model number, and where the equipment may be obtained. If it is recommended that the worksite be modified, or specific duties be restructured or shared, describe the necessary action.
9. Healthcare provider's credentials must be identified (M.D., R.N., Physical Therapist, etc.).

To ensure confidentiality, medical certification may be sent directly to:

Department of General Services
Office of Human Resources
Return to Work Unit
707 Third Street, 7th Floor
West Sacramento, CA 95605

Or by fax: (916) 376-5395

Or by email: ReasonableAccommodation@dgs.ca.gov

SECTION C: TO BE COMPLETED BY THE MANAGER/SUPERVISOR	
Document all interactive discussions with the employee/applicant before submitting to the Office of Human Resources. Include dates of the discussion(s), specific request(s), names of all individuals present during the discussion(s), and other relevant information. Use additional pages if needed. If assistance is needed, contact the Reasonable Accommodation Coordinator at ReasonableAccommodation@dgs.ca.gov.	
DATE	DISCUSSION NOTES
List all potential reasonable accommodations identified in the interactive discussions and the strengths and weaknesses for each as a potential reasonable accommodation.	
List your recommended reasonable accommodation(s) and the reason for the recommendation:	
Supervisor Name:	Classification:
Supervisor Signature:	Date:

SECTION D: TO BE COMPLETED BY THE OFFICE OF HUMAN RESOURCES
Accommodation(s) to be provided:
Accommodation(s) that cannot be provided and reason(s):
Reasonable Accommodation Coordinator Name: _____ Reasonable Accommodation Coordinator Signature: _____ Date: _____