NORTH ORANGE COUNTY COMMUNITY COLLEGE DISTRICT

Cypress College Fullerton College NOCE NORTH ORANGE CONTINUING EDUCATION

PHYSICIAN'S STATEMENT FORM - CONFIDENTIAL

Department of Human Resources
1830 W. Romneya Drive, Anaheim, California 92801
Phone: (714) 808-4800 Fax: (714) 808-4802 Email: benefits@nocccd.edu

The California Fair Employment and Housing Act requires employers of five or more employees to provide reasonable accommodation for individuals with a physical or mental disability to perform the essential functions of their job 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 a reasonable accommodation. This form and any supporting materials or information is confidential and should be kept separate from an employee's personnel file.

SECTION A: TO BE COMPLETED BY EMPLOYEE	
NAME OF EMPLOYEE	CLASSIFICATION/JOB TITLE
WORK LOCATION/SUPERVISOR	WORK TELEPHONE NUMBER/EMAIL
ACCOMMODATION(S) REQUESTED: (Be as specific as possible, for example adaptive equipment, reader, interpreter, training, schedule change, etc.)	
REASON FOR REQUEST: (Please do not disclose your diagnosis; explain your disability-related limitations and how this accommodation will help you do your job.)	
IS YOUR LIMITATION: ☐ Permanent ☐ Temporary ☐ Unknown	ANTICIPATED RECOVERY DATE (if any)
IS THE ABOVE DESCRIBED DISABILITY THE SUBJECT OF A WORKER'S COMPENSATION CLAIM? (Employees with work related injuries may also be eligible for a reasonable accommodation independent of the worker's compensation process.) ☐ YES ☐ NO IF YES, DATE FILED:	
HAVE YOU REQUESTED FMLA, CFRA, PDL, OR OTHER LEAVE IN CONNECTION WITH THE ABOVE DESCRIBED DISABILITY? ☐ YES ☐ NO IF YES, PLEASE SPECIFY WHAT YOU REQUESTED AND WHEN:	
I CERTIFY THAT I HAVE A DISABILITY THAT REQUIRES REASONABLE ACCOMMODATION, WHICH WILL BE MET BY THE ACCOMMODATION(S) LISTED ABOVE.	
SIGNATURE OF EMPLOYEE	**DATE**

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PHYSICIAN'S NOTICE OF RETURN TO WORK OR FURTHER TREATMENT

The policies of our organization are to return our employees with work restrictions / work limitations to work as soon as they are deemed medically able to do any productive type of work. Please complete and return this notice with your patient before they leave your office.

PATIENT'S / EMPLOYEE'S WORK STATUS

☐ DISCHARGED – RETURN TO WORK WITHOUT LIMITATIONS / RETURNED TO FULL DUTY / REGULAR WORK NO WORK RESTRICTIONS
☐ RETURNED TO WORK – WITH TEMPORARY WORK RESTRICTIONS, AS NOTED BELOW, THROUGH:_____ (date)
☐ UNABLE TO RETURN TO WORK IN ANY CAPACITY / TOTALLY TEMPORARILY DISABLED THROUGH:_____(date)
☐ NEXT APPOINTMENT / OFFICE VISIT WILL BE ON_____(date) at_____a.m. / p.m. ☐ NO FOLLOW UP / DISCHARGED

WORK RESTRICTIONS / WORK LIMITATIONS

RESTRICTED PHYSICAL DEMAND: (BOXES NOT FILLED OUT WILL BE VIEWED AS UNRESTRICTED PHYSICAL DEMANDS)	ABLE TO PERFORM	MAXIMUM MINUTES AT ONE TIME	MAXIMUM REPETITIONS	MAXIMUM HOURS PER
☐ RESTRICTED TO LIFTING A MAXIMUM OF_____LBS. ALONE	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ RESTRICTED TO PUSHING/PULLING A MAX OF_____ LBS.	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ RESTRICTED TO CARRYING A MAXIMUM OF_____LBS. ALONE	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ RESTRICTED TO SITTING; SEDENTARY TYPE WORK ONLY	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ RESTRICTED TO STANDING, NON-WALKING ACTIVITIES	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ RESTRICTED TO WALKING SHORT / LONG DISTANCES	☐ No ☐ Yes	_____Minutes at one time	_____Max Dist. Per Hour	_____Hours per shift
☐ RESTRICTED WEIGHTBEARING (STANDING AND WALKING)	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ RESTRICTED TO WALKING ON UNEVEN GROUND	☐ No ☐ Yes	_____Minutes at one time	_____Max Dist. Per Hour	_____Hours per shift
☐ RESTRICTED TO RUNNING / WALKING IN A FAST PACE	☐ No ☐ Yes	_____Minutes at one time	_____Max Dist. Per Hour	_____Hours per shift
☐ NECK: NEUTRAL POSITION, LOOKING FORWARD	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ NECK: FLEXION / EXTENSION ☐ Up ☐ Down	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ NECK: TWIST AND TURN ☐ Left ☐ Right	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ SHOULDER: REACH BELOW ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ SHOULDER: REACHING AT/ABOVE ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ SHOULDER: REACHING OVERHEAD ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ WAIST: BEND / STOOP	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ WAIST: TWIST / TURN / LATERAL BEND	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ KNEES: SQUAT / KNEEL ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ HAND: TYPE / KEYBOARDING ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ HAND: MANIPULATE COMPUTER MOUSE ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ HAND: FINE MANIPULATION ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ HAND: SIMPLE GRIP / GRASP ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ HAND: POWERFUL GRIP / GRASP ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ WRIST: SIDE TO SIDE MOTION ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ WRIST: UP AND DOWN FLEXION ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ WRIST: TURN / TWIST / TORQUE ☐ Left ☐ Right ☐	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ OPERATE POWER TOOLS (VIBRATE)	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift
☐ OPERATE MACHINERY / DRIVE VEHICLE	☐ No ☐ Yes	_____Minutes at one time	_____Max Reps. Per Hour	_____Hours per shift

ADDITIONAL PHYSICIAN COMMENTS / ADDITIONAL WORK RESTRICTIONS

☐ **EMPLOYEE REQUIRES** ☐ Sedentary work only ☐ Semi-sedentary work, w/ the ability to sit or stand at will, every_____☐ minutes ☐ hour(s) ☐ only as needed
☐ **EMPLOYEE REQUIRES USE OF** ☐ Wrist Brace/Splint ☐ Arm Brace ☐ Back Brace/Support ☐ Crutches ☐ Walker ☐ Cane ☐ Required ☐ optional, as needed
☐ **EMPLOYEE REQUIRES A_____MINUTE SITTING BREAK, AFTER STANDING AND / OR WALKING EVERY_____** ☐ minutes ☐ hour(s) ☐ only as needed
☐ **EMPLOYEE REQUIRES A STANDING / WALKING BREAK, OF_____MINUTES, AFTER SITTING EVERY_____** ☐ minutes ☐ hour(s) ☐ only as needed
☐ **EMPLOYEE REQUIRES A_____MINUTE BREAK FROM ALL WORK-RELATED ACTIVITIES, AFTER_____** ☐ minutes ☐ hour(s) Of Work ☐ only as needed
☐ **NO DIRECT SUN LIGHT** ☐ **NO EXPOSURE TO UNDUE STRESS** ☐ **NEEDS TO ELEVATE LEG/FOOT EVERY_____** ☐ minutes ☐ hour(s) ☐ only as needed
☐ **NO WORK IN EXTREME TEMPERATURES** ☐ Above:_____Degrees ☐ Below:_____Degrees ☐ **REQUIRES AN ERGONOMIC WORKSTATION / DESK**
☐ **OTHER**: _____

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SECTION B: CERTIFICATION FROM PHYSICIAN/HEALTH CARE PROVIDER

When an employee's disability or need for accommodation is not apparent or known to the employer, the employer may request a certification from a health care provider verifying that an accommodation is necessary. The employer should provide the employee with a copy of a job duty statement to share with the health care provider.

FOR COMPLETION BY THE HEALTH CARE PROVIDER

Please provide a letter or verification addressing the following:

1. Verification that the employee has a disability (but not the diagnosis).
2. Description of how the employee's limitations impair the ability to perform the duties of the job and indication of whether these limitations are temporary or permanent.
    a. If temporary, state when they are expected to end.
3. Recommendation of specific reasonable accommodation(s).

(Note: Use the space below or attach a letter or verification, which will be kept confidential. Employers must generally retain medical certifications and related documents separately from usual personnel files.)

DATE ACCOMMODATION TO BEGIN	**DATE ACCOMMODATION TO END OR CONTINUOUS**
NAME OF HEALTH CARE PROVIDER	**SIGNATURE OF HEALTH CARE PROVIDER**

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SECTION C: TO BE COMPLETED BY EMPLOYER

LIST SPECIFIC ACCOMMODATION(S) TO BE PROVIDED:

For each accommodation requested by the employee that you deny, explain the reason for the denial: (may check more than one box, use additional pages if need).

- ☐ Accommodation Ineffective
- ☐ Accommodation Would Cause Undue Hardship. Identify Hardship: _____
  _____
- ☐ Medical Documentation Inadequate
- ☐ Accommodation Would Require Removal of an Essential Job Function. Identify Function: _____
  _____
- ☐ Accommodation Would Require Lowering of Performance or Production Standard. Identify Standard:
  _____
- ☐ No Alternative Vacant Position Available. Positions Considered: _____
  _____
- ☐ Employee Rejected Alternative Accommodation. Identify Accommodation Offered and Reason for Employee's Rejection:
  _____
- ☐ Other (Please identify):

Further Explanation/Comments:

ACKNOWLEDGEMENT OF RECEIPT OF REASONABLE ACCOMMODATION REQUEST	**DATES**
DATE ACCOMMODATION TO BEGIN	
DATE ACCOMMODATION TO END	
DATE EQUIPMENT ORDERED IF NEEDED AND BY WHOM	
DATE EQUIPMENT WAS RECEIVED BY EMPLOYEE	

SECTION E: TO BE COMPLETED BY EMPLOYER FOLLOWING IMPLEMENTATION OF THE ACCOMMODATION(S)

The employer should check in periodically with the employee to ensure that the accommodation is effective. If the accommodation is not effective, there is a duty to reengage in the interactive process

Document all interactive discussions with employee, including dates of the discussions, names of all persons present, what was discussed, and next steps if needed. Use additional pages if needed.