West Contra Costa Unified School District
Human Resources Department
1108 Bissell Avenue
Richmond, CA 94801

Phone (510) 231-1185
Fax (510) 236-0171

Human Resources Department

REQUEST FOR REASONABLE ACCOMMODATION

COVID Vaccine Employee Questionnaire

Please return completed form to the Human Resources Department

Date	
Name	
Department	
Email address	
Job title	
Phone numbers (home, office and cell)	
Home address	
Supervisor's Name	

Please complete the following:

1. What, if any, job function are you having difficulty performing?
2. What, if any, employment benefit are you having difficulty accessing?
3. What limitation(s) is interfering with your ability to perform your job or access an employment benefit?

   Have you had any accommodations in the past for this same limitation? ☐ NO ☐ YES
   If *yes*, what were they and how effective were they?
4. Is there any additional information that you would like the District to be aware of that may assist in this process. Please do not provide any information on your diagnosis, condition or treatment.

I certify that the above is true and accurate.

Employee's Original Signature Date

Received

Signed Print Name Date Received

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REQUEST FOR REASONABLE ACCOMMODATION

Physician Questionnaire

To: Employee's Personal Physician
From: Human Resources Department

Via: **Patient's Name:** _____
Re: Patient's Request For Reasonable Accommodation Medical Questionnaire

Your patient is in the process of requesting reasonable accommodations from the District to assist him/her to perform the essential functions of his/her position safely. In compliance with the Fair Employment and Housing Act (Government Code § 12940) and Title I of the Americans with Disabilities Act (42 U.S.C. § 12101, et seq.), your assistance is requested to provide information in support of this request. Please answer the following questions and provide the completed questionnaire to your patient, who will return it, with her full application, to the District's Human Resources Department for use in his/her interactive process.

Physician's Name: _____ **License Number:** _____

Physician's Phone Number: _____

Date of Examination: _____

(Check boxes and insert text as appropriate)

1. Does Your patient have a physical or mental impairment that limits his/her ability to engage in a major life activity, such as the ability to work, care for his/herself, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities. Pursuant to the FEHA amendments that went into effect on January 1, 2001, a condition can be said to "limit" one if the condition makes the achievement of the major life activity more difficult.

   ☐ NO, Your patient does not have a physical or mental impairment that limits his/her ability to engage in a major life activity.

   ☐ YES, Your patient has a ☐ PHYSICAL and/or ☐ MENTAL impairment that limits his/her ability to engage in a major life activity.

2. If the answer to question number one is yes, does the impairment currently affect your patient's ability to perform the essential functions of their position (see attached job description).

   ☐ NO, Your patient's impairment does not limit his/her ability to perform all of the essential functions of his/her position.

   ☐ YES, Your patient's impairment does affect his/her ability to perform the essential functions of their position.

3. If the answer to question number two is yes, what work restriction(s) or functional limitations does his/her disability produce that are in need of accommodation? Please be as specific as possible. (e.g. if providing a restriction to standing, how many minutes can she stand before she would need to sit for X minutes, etc.) **List all necessary work restrictions with sufficient detail so all parties will understand how to interpret and apply them:**

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☐ Restrictions are **TEMPORARY through _____ (date)** ☐ Restrictions are **PERMANENT**

1. **VACCINATION CLARIFICATION**: Is [Mr./Ms. Name] eligible to receive the COVID-19 vaccine with their medical condition?
   ☐ NO, [Mr./Ms. Name] is medically restricted from being administered a COVID-19 vaccination due to their personal medical condition.
   ☐ YES, [Mr./Ms. Name] is NOT medically restricted from being administered a COVID-19 vaccination; this would be a preference of my patient and not medically restricted.
   ☐ OTHER: _____

   a. If you have indicated in question #1 question above that your patient is ABLE to receive the COVID-19 vaccine, do you anticipate they will be able to RETURN to the workplace once vaccinated?
   ☐ NO, [Mr./Ms. Name] WILL NOT be able to return to the workplace even AFTER being vaccinated, the following restrictions will remain in place: _____
   ☐ YES, [Mr./Ms. Name] WILL be able to return to the workplace after being vaccinated.
   ☐ OTHER: _____

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4. Does your patient's continued assignment to their job pose a significant risk of substantial harm to the health and safety of the employee or others?

   ☐ NO ☐ YES, complete question # 5 and # 6 below.

5. If the answer to question number four is yes, identify the duration, nature, severity, likelihood and imminence of each specific risk.

6. If the answer to question number four is yes, identify any specific work restrictions(s), that if accommodated, would reduce or eliminate the risk(s) described in question number five.

7. Additional Restrictions / Accommodation Suggestions / Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee.

Physician's Original Signature Date

Please return this completed form to your patient.