



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



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: _____



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



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.