ADA/FEHA COVID-19 Disability Accommodation Certification

Instructions: Please note, this request form should be utilized for **COVID related disability accommodations**. Employee/applicant shall contact the treating health care provider to complete this form. Employee/ applicant should return the completed form to ADA coordinator at SJSU.

To: _____ Re: _____

Treating Doctor/Health Care Provider | Employee/Patient Name

Treating Health Care Provider: *Please complete the following:*

1. Does your patient have a disability and/or medical condition that makes them "higher risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19?

   ☐ Patient ***DOES NOT HAVE*** a disability and/or medical condition that makes them "higher risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19.

   ☐ Patient ***DOES HAVE*** a disability and/or medical condition that makes them "higher risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19. Patient is *MEDICALLY RESTRICTED* from coming into the workplace, even with PPE employed and social distancing being observed. (Please skip to 1.a. and #2 below and sign, date and return the form).

   ☐ Patient ***DOES HAVE*** a disability and/or medical condition that medically requires LIMITING their exposure to coronavirus and/or COVID-19, but not "higher risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19 (Please continue completing the form)

   a. PLEASE IDENTIFY ALL APPLICABLE DISABILITY/MEDICAL EMPLOYEE/PATIENT **RESTRICTIONS**:

2. **DURATION OF COVID-19 RELATED RESTRICTIONS:** Please confirm the duration of restrictions by checking the appropriate box below:

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

   ☐ Restrictions are **PERMANENT**

   ☐ Restrictions are expected to continue as follows (please explain):

b. PLEASE IDENTIFY WORKPLACE **RISKS** THAT NEED TO BE ACCOMMODATED OR MITIGATED TO ENSURE A SAFE WORK ENVIRONMENT FOR YOUR PATIENT. WHAT IS IN THE PHYSICAL WORKPLACE THAT IS A MEDICAL RISK FOR YOUR PATIENT:

c. PLEASE IDENTIFY WORKPLACE **FACTORS** THAT MUST BE PRESENT IN A WORKPLACE TO ENSURE YOU'RE YOUR PATIENT IS SAFE. ***WHAT ACCOMMODATIONS*** NEED TO BE IMPLEMENTED FOR YOUR PATIENT IN ANY WORK ENVIRONMENT THEY WORK IN?

3. **CURRENT WORK ENVIRONMENT:** SJSU will/can implemented the following social distancing and cleaning protocols which meet or exceed OSHA and CDC guidelines for workplace safety:

- All workplace safety requirements per the CDC, Cal/OSHA, and the California Department of Public Health (CDPH)
- CSU Vaccination including booster for students, faculty, and staff accessing University facilities
- Optional COVID-19 testing for all campus community
- Personal Protective Equipment (PPE) such as face coverings, disinfection supplies, hand sanitizer, gloves, and other PPE made available at building entrances or by request to students, faculty, staff

The above list of safety measures will/can be taken to protect your patient and their colleagues as their work has been deemed mission critical/essential to the business. Are the above measures sufficient to support your patient's to return to the workplace:

☐ YES, the above measures are sufficient to support my patient to return to the workplace.

☐ NO, the above measures are insufficient to support my patient to safely return to the workplace. The following safety precautions also need to be implemented/present:

4. **COMMUTE QUESTION:** Is your patient's request for a work-from-home accommodation related to his/her commute to San Jose, CA?

   ☐ NO, the recommendation for an accommodation is NOT related to my patient's commute.

   ☐ YES, the recommendation for an accommodation IS related to my patient's commute. The commute concern relates to:

      ☐ he/she uses public transportation or

      ☐ other, explain:

5. **PERSONAL PROTECTION EQUIPMENT CLARIFICATION:**

   a. Does your patient medical condition require specific personal protection equipment?

      ☐ NO, Patient's medical condition ***DOES NOT*** require specific personal protection equipment.

      ☐ YES, Patient's medical condition ***DOES*** require specific personal protection equipment as follows (check all that apply):

         ☐ Medical Mask

         ☐ Respirator with rating greater than: _____

         ☐ Face Shield

         ☐ Cloth Masks

         ☐ Hand Gloves

         ☐ Gowns

         ☐ Aprons

         ☐ Eye Protection

         ☐ Footwear Covers

         ☐ Other:

6. **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. **Please do not list any information pertaining to medical condition or diagnosis.**

Doctor/Healthcare Provider Print	Date
Doctor/Healthcare Provider Signature	License Number
Healthcare Provider Address	

Verified by ADA Coordinator	Date

Form can be returned to:
Melanie Nguyen
Employment Accommodation Analyst, EARC
Email: melanie.nguyen@sjsu.edu or Fax: (408) 924-4358