SONOMA STATE UNIVERSITY | PAYROLL & BENEFITS

DISABILITY INTERACTIVE PROCESS:
REQUEST FOR CLARIFICATION ON WORK RESTRICTIONS / REQUEST FOR ACCOMMODATION

On behalf of my patient, based on my review of the current job description, I can provide the following clarification on their work restrictions:

Patient Name: _____

(Check boxes and insert text as appropriate)

1. Does your patient have a physical and/or mental impairment that limits the ability to engage in a major life activity, such as the ability to work, care for themselves, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities?
   - ☐ NO, my patient does not have a physical or mental impairment that limits their ability to engage in a major life activity.
   - ☐ YES, my patient has a ☐ PHYSICAL and/or ☐ MENTAL impairment that limits their 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 in the job description provided?
   - ☐ NO, my patient's impairment does not limit their ability to perform all of the essential functions of their position as defined in the job description provided.
   - ☐ YES, my patient's impairment does affect their ability to perform **one or more** of the essential functions of their position of as defined in the job description provided.

3. 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?
   - ☐ My 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.
   - ☐ My 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. My patient is MEDICALLY RESTRICTED from coming into the workplace, even with the current safety measures in place. (Please see #4 for the current work environment).
   - ☐ My 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

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a. **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?**

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

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4. **CURRENT WORK ENVIRONMENT:** SSU has implemented the following protocols which meet or exceed OSHA and CDC guidelines for workplace safety:

   - Wellness Reporting Tool for positive cases on campus
   - Air handling exceeds requirements including a minimum of 4 air exchanges per hour using MERV-14 filtration

   The above safety measures have been implemented to protect your patient and their colleagues. Are the above measures sufficient to support your patient 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: (please be specific) _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   ☐ OTHER / ADDITIONAL INFORMATION: _____

   _____

   _____

   _____

   _____

   _____

   _____

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5. **PERSONAL PROTECTION EQUIPMENT CLARIFICATION**: Does your patient's medical condition require specific personal protection equipment?

   ☐ NO, my patient's medical condition DOES NOT require specific personal protection equipment.
   ☐ YES, my 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
      ☐ Hand Gloves
      ☐ Eye Protection
      ☐ Gowns
      ☐ Aprons
      ☐ Eye Protection
      ☐ Footwear Covers
      ☐ Other: _____

6. **DURATION OF 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): _____

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

_____ _____

Treating Physician's Signature Date

_____ _____

Printed Name License Number

RETURN A COPY OF THIS FORM TO:
Fax (707) 664-4049 or hraccommodations@sonoma.edu