**PERSONAL INFORMATION NOTICE**

This document contains personal information, and pursuant to Civil Code Section 1798.21, shall be kept confidential in order to protect against unauthorized disclosure. This information will only be used to determine an effective accommodation, if possible, for your work-related limitations. Verification is required of disabilities or medical conditions.

**Instructions for Completing the Form:**

Complete Part 1 of the form and the employee portion of the medical release in Part 2. Provide the completed form to your treating physician with a copy of your Essential Functions Duty Statement, classification specification for your current position from the California Department of Human Resources (CalHR), and for Bargaining Unit 8 safety employees, a Physical/Mental Stress Duty Statement. Your physician must complete Part 3. Mail or fax the fully completed form to:

**CAL FIRE Reasonable Accommodation Coordinator**

**Human Resource Management - Occupational Health and Wellness Program**

**P. O. Box 944246, Sacramento, CA 94244-2460**

**Confidential Fax: (916) 445-8129**

|  |  |
| --- | --- |
| EMPLOYEE NAME | WORK UNIT |
| EMPLOYEE HOME ADDRESS | EMPLOYEE HOME OR CELL PHONE NUMBER |
| EMPLOYEE JOB CLASSIFICATION | EMPLOYEE WORK PHONE NUMBER |
| SUPERVISOR NAME | SUPERVISOR WORK PHONE NUMBER |
| **Describe the limitation that requires accommodation:** | |
| **Type of accommodation requested:** *(If more space is needed, please attach additional information.)* | |
| **Describe how this accommodation will enable you to perform the essential duties of the position:** | |
| **Employee Signature** | **Date** |

**Authorization for Release of Medical Information**

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| Physician Name: |
| Physician Address: |
| Physician Telephone Number: |
| Name of Patient: |

(Please type or print clearly in blue or black pen.)

Dear Doctor       :d:

I, Enter Your Name, hereby authorize the above-named physician(s) to release to CAL FIRE any and all medical information regarding my work limitations and the information requested in Part 3 of this form. This authorization shall be valid for a period of 6 months from the date of my signature or earlier if revoked by me in writing to the Reasonable Accommodation Coordinator in CAL FIRE’s Occupational Health and Wellness Program. This information shall be provided to:

CAL FIRE Reasonable Accommodation Coordinator

Occupational Health and Wellness Program

P. O. Box 944246, Sacramento, CA 94244-2460

-or- Confidential Fax: (916) 445-8129

The information is to be provided for the limited purpose of determining whether I have a disability and whether I can perform the essential functions of my position or any other position at CAL FIRE.

I hereby acknowledge that I have been informed of my right to receive a copy of this authorization upon request. A photocopy of this release shall be as valid as the original.

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| --- |
| Signature: *(Employee, their spouse or legal representative)* |
| Date: |

**Medical Provider’s Report Regarding Request for Reasonable Accommodation**

To the Medical Provider: The employee listed in Part 2 of this form has applied for reasonable accommodation, which is a logical adjustment made to a job or the work environment that enables a qualified person with a disability to enjoy equal employment opportunities. Under the California Fair Employment and Housing Act (FEHA), an individual with a disability is a person who:

* has a physical or mental impairment or medical condition that limits one or more major life activities (a major life activity may include walking, breathing, speaking, performing manual tasks, seeing, hearing, learning, caring for oneself, sitting, standing, lifting, reading or working);
* has a record of such impairment or condition, or;
* is regarded as having such an impairment or condition.

Taking the above definition into consideration, please review the Position Essential Functions Duty Statement, CAL HR Classification Specification, and if applicable, the Physical/Mental Stress Job Description. Please answer the following questions with respect to our employee’s request for reasonable accommodation: (if more space is needed, please attach additional information.)

|  |  |
| --- | --- |
| 1. Does the employee have an impairment or medical condition that limits a major life activity? Yes  No | |
| 1. Is this disability permanent? Yes  No  If not permanent, anticipated duration: | |
| 1. Identify the employee’s job-related limitations. | |
| 1. Based on the enclosed duty statement, specify the duties the employee cannot perform with accommodation: | |
| 1. What type of accommodation do you recommend for the employee? | |
| Medical Provider’s Name (Print) | Date |
| Medical Provider’s Signature | |
| Address (Print) | |
| Telephone | |