LOS ANGELES COMMUNITY COLLEGE DISTRICT

**FORM B-32B: Licensed Health Care Provider Questionnaire Form (for Employee Accommodation Request to be completed by the Health Care Professional)**

# Employee Information

Name:

Phone Number:

Work Location: DISTRICT OFFICE  CITY  EAST  HARBOR  MISSION  PIERCE  SOUTHWEST  TRADE TECH  VALLEY  WEST  VAN DE KAMP  SOUTH GATE

Date of Examination:

# Questions to Help Determine Whether an Employee Has a Disability

For reasonable accommodation under the Americans With Disabilities Act (“ADA”) and the Fair Employment and Housing Act (“FEHA”), an employee has a disability if he or she has an impairment that limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability.

I have reviewed the Job Description/Job Analysis for the employee’s position of      , and can provide the following clarifications (*check boxes and insert text as appropriate*):

1. Does the employee 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?

**YES** the employee has a PHYSICAL and/or MENTAL impairment that limits his/her ability to engage in a major life activity.

**NO** the employee does not have a physical or mental impairment that limits his/her ability to engage in a major life activity.

1. If the answer to question number one is yes, does the impairment currently affect the employee’s ability to perform the essential functions of a       (*see attached job description*)?

**YES** the employee’s impairment does affect his/her ability to perform the essential functions of his/her position.

**NO** the employee’s impairment does not limit his/her ability to perform the essential functions of his/her position.

1. If the answer to question number two is yes, what work restriction(s) or functional limitation 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 before the employee would need to sit, etc.). List all necessary work restrictions with sufficient detail so all parties will understand how to interpret and apply them:

Restrictions are **PERMANENT**

Restrictions are **TEMPORARY** through       date.

**List all physical activity restrictions:**

No repetitive lifting/carrying of       pounds or more

No lifting/carrying of       pounds or more

No repetitive pushing/pulling of       pounds or more

No pushing/pulling of       pounds or more

No at or above shoulder level reaching greater than       seconds/minute

No repetitive bending/stooping greater than       times/row

No repetitive keyboarding in excess of       minutes per hour

No prolonged walking in excess of       minutes

No repetitive squatting/kneeling greater than       times/row

No prolonged standing in excess of       minutes

No prolonged sitting in excess of       minutes

Must alternate sitting/standing every       minutes

No running

No jumping

No climbing

Other (please be specific):

**Additional clarifications/restrictions:**

1. Additional restriction/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.

**Licensed Health Care Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:**

**Print Name:**

**California Physician License Number:**

**PLEASE RETURN A COPY OF THIS FORM VIA FAX TO:**

*All medical information shared with the District through the ADA/ADAAA and FEHA evaluation and/or reasonable accommodation process will be maintained separate from personnel files and in accordance with State and Federal requirements.*

*The Los Angeles Community College District does not discriminate on the basis of disability in the admissions or access to, or treatment of or employment in, its programs or activities. Requests for alternate formats can be made by contacting the ADA Compliance Administrator.*

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by Title II of GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services*.