ADMINISTRATIVE INSTRUCTION

SUBJECT: Reasonable Accommodations Regarding Employment **NUMBER:** III - 4 - 3

EFFECTIVE DATE: October 19, 2011 **PAGE:** 1 of 22

I. Purpose

The purpose of this Administrative Instruction is to set forth procedures by which the City of Santa Monica will determine if a Reasonable Accommodation is necessary and, if so, provide Reasonable Accommodations to Applicants and Employees as required by the California Fair Employment and Housing Act (FEHA - Government Code §§ 12940, et seq.) and Title I of the Americans with Disabilities Act (ADA - 42 U.S.C. §§ 12101, et seq.).

II. Scope

This Administrative Instruction applies to all Applicants and Employees.

III. Definitions

A. **ADA:** The Americans with Disabilities Act (42 U.S.C. §§ 12101, et seq.).

B. **Alternative Work:** An Employee's performance of an assignment other than in his or her regular position. Alternative Work may be temporary, long-term, or permanent. Temporary Alternative Work may encompass tasks not organized in an approved classification, but assigned to allow a disabled Employee to remain working for a short duration of time. Long-term or permanent Alternative Work requires that: 1) there is a vacancy in the City approved to be filled; 2) the disabled Employee is minimally qualified to perform the work; 3) the disabled Employee is able to perform the work with or without Reasonable Accommodation; 4) the salary for the Alternative Work is the same or less than the disabled Employee's current classification's salary; and 5) the assignment to Alternative Work does not contravene a memorandum of understanding between the City and any bargaining unit.

C. **Applicant:** A person applying for any position at the City who has not yet been selected.

D. **Appointing Authority:** The authority that hired Employee; in most cases, this will be the director of the Employee's department.

E. **CalPERS:** The California Public Employees' Retirement System.

F. **Committee:** The City's accommodations committee, which coordinates the Interactive Process and makes decisions pertaining to Reasonable Accommodation. The Committee typically consists of persons from the Human Resources Department, the City Attorney's Office, the Risk Management Division, and the Eligible Person's Department. The Committee may include additional members on a case-by-case basis to support the Interactive Process.

G. **Coordinator:** The position designated in the Human Resources Department to manage the Interactive Process and support the efficient operation of the Committee.

H. **Direct Threat:** A significant risk of substantial harm to the health or safety of self or others that cannot be eliminated or reduced through Reasonable Accommodation.

I. **Director:** The Human Resources Director, unless otherwise indicated.

J. **Disability:** Any disability or condition that meets the definition of physical disability, mental disability, or medical condition contained in FEHA or the ADA.

K. **Eligible Person:** Any Applicant or Employee with a Disability.

L. **Employee:** Any person employed at the City, whether probationary, permanent, at-will or by employment contract, including temporary agency staff or contractors working under the City's control or supervision. Unless otherwise indicated specifically or by context, Employee shall include any person who has been offered a position at the City but has not begun employment at the City.

M. **Essential Functions:** Essential functions are the basic job duties that an Employee must be able to perform, with or without reasonable accommodation. Factors to consider in determining if a function is essential include: whether the reason the position exists is to perform that function, the number of other employees available to perform the function or among whom the performance of the function can be distributed, and the degree of expertise or skill required to perform the function.

The City's judgment as to which functions are essential, and a written job description prepared before advertising or interviewing for a job will be considered as evidence of essential functions. Other kinds of evidence that will be considered include: An Essential Functions Job Analysis, the actual work experience of present or past employees in the job, the time spent performing a function, the consequences of not requiring that an employee perform a function, and the terms of a collective bargaining agreement.

N. **Essential Functions Job Analysis**: An Essential Functions Job Analysis objectively identifies the core physical, mental and emotional requirements of a position. The document is used to assist with determining how an employee's work restrictions may impact the core physical/mental/emotional demands of a position.

O. **FEHA:** The California Fair Employment and Housing Act (Government Code §§ 12900, et seq.).

P. **Health Care Provider**: Any person or entity defined as a Health Care Provider by FEHA or the ADA, or any regulations adopted pursuant to FEHA or the ADA.

Q. **Interactive Process:** The good faith process between the City and an Eligible Person with a known disability, which includes: consulting with an Eligible Person to ascertain the precise job-related limitations and how the limitations could be reasonably accommodated; and identifying potential accommodations and assessing their reasonableness and effectiveness.

R. **Modified Work:** An Employee's performance of all the essential functions of his or her current job classification with the support of Reasonable Accommodation(s). Modified Work may be temporary, long-term, or permanent.

S. **Permanent Employee:** Any Employee who has completed the probationary period for his or job classification or whose employment is at-will.

T. **Permanent or Long-Term Disability:** A Disability that a Health Care Provider expects to continue for an indeterminate amount of time or for the life of the Eligible Person.

U. **Probationary Employee:** Any employee serving a probationary period.

V. **Reasonable Accommodation:** Any appropriate measure that would allow an Eligible Person to perform the essential functions of his or her job classification. A Reasonable Accommodation may include, but is not limited to, the following: making facilities accessible to individuals with disabilities, restructuring jobs, modifying work schedules, buying new or modifying existing equipment, or modifying examinations and policies.

W. **Temporary or Short-Term Disability:** A Disability that a Health Care Provider expects to last for a specific amount of time, typically for not longer than six months.

X. **Undue Hardship:** A significant difficulty or expense required to grant the requested accommodation, including but not limited to:

1. Nature and cost of the accommodation needed;
2. Overall financial resources of the facility making the Reasonable Accommodation;
3. Effect on expenses and resources of the facility;
4. Impact of the accommodation on the operation of the facility;
5. Impact of the accommodation on other employees; and
6. Impact of the accommodation on the public service.

IV. Policy

The City of Santa Monica is committed to complying with FEHA and the ADA. In support of this commitment, the City has created this Administrative Instruction to provide guidance to City departments on how to address Reasonable Accommodation requests and needs. The City has created the Committee to coordinate the Interactive Process set out in this Administrative Instruction and to ensure compliance with applicable laws.

V. Procedures and Responsibilities

PROCEDURES

The City will use the following procedures for handling: (A) requests for Reasonable Accommodations by Applicants or Employees; and (B) the City's perception that an Employee may need a Reasonable Accommodation.

A. Requests for Reasonable Accommodations.

1. Applicants.

a. An Applicant may request a Reasonable Accommodation related to the City's examination process by completing the Applicant Request for Accommodation form (Form A) and submitting it to the Human Resources Department at least three work days prior to the examination. The Applicant must specifically identify the accommodation that he or she requests for the examination process. Along with the Applicant Request for Accommodation form, an Applicant must submit a certification of Disability from a Health Care Provider at the Applicant's own expense.

b. If a Health Care Provider certifies that an Applicant has a Disability, the Human Resources Department will decide if the requested accommodation is a Reasonable Accommodation. If the Human Resources Department determines that the requested accommodation is a Reasonable Accommodation, the Human Resources Department will provide the Applicant with the Reasonable Accommodation at or prior to the time of the examination.

c. If the Applicant fails to submit a certification of Disability from a Health Care Provider or if the Human Resources Department determines that the requested accommodation is not a Reasonable Accommodation, the Human Resources Department will inform the Applicant verbally of the decision denying the requested accommodation prior to the examination time. A written notice advising of the decision will follow that same day via e-mail or the United States Postal Service.

d. If an Applicant disagrees with the determination made by the Human Resources Department, he or she may request a review of the determination by the Director within seven calendar days of the date of the determination. The Director's decision regarding a requested accommodation is final.

Responsible Persons: Applicant / Human Resources Employment and Organizational Development Division / Human Resources Director

2. Employees.

a. Temporary or Short-Term Disability.

i. Any Employee with a Temporary or Short-Term Disability who believes that he or she is in need of a Reasonable Accommodation may notify his or her direct supervisor of the need orally or in writing. Please note that Workers' Compensation staff will coordinate this process for Employees with industrial injuries, and provide the necessary medical certification information.

ii. Upon receiving such oral or written notice, the Employee's supervisor will notify the Coordinator of the request for Reasonable Accommodation. The Coordinator will contact the Employee, direct him or her to this Administrative Instruction with the attached forms, and assist the Employee through the Interactive Process as necessary.

iii. The Employee must complete the Request for Temporary or Short-Term Reasonable Accommodation form (Form B) and submit it to the Coordinator.

iv. Within fourteen calendar days of submitting the Request for Temporary or Short-Term Reasonable Accommodation form to the Coordinator, the Employee must submit a certification of Disability from a Health Care Provider, certifying that the Employee has a Disability and listing the type and duration of any work restriction(s) associated with the Disability. The Employee can use the Medical Certification form (Form C) or a written communication from a Health Care Provider to satisfy this requirement.

v. Upon receipt of the form and certification, the Coordinator will review the request and the work restriction(s) with the Employee and the Employee's department. If the department is able to offer the Employee Modified Work or Alternative Work, the Coordinator will provide a Temporary Modified / Alternative Duty agreement (Form D) to be signed by the Employee, the department, and the Coordinator.

vi. If an Employee is off work because of his or her Disability, the Employee will typically remain off work, using available paid and unpaid leaves. If the Coordinator determines that the City can provide a Reasonable Accommodation through Modified Work or Alternative Work, the Employee must sign a Temporary Modified/Alternative Duty agreement prior to returning to work. An Employee's failure to sign the agreement constitutes a refusal of the Modified Work or Alternative Work, and may result in the Employee remaining off work in an unpaid status.

vii. If the Coordinator determines that Modified Work or Alternative Work is not available or if an accommodation request is not reasonable, the Coordinator will document the reasons for this determination on the Unable to Accommodate form (Form E). The Coordinator will notify the Employee in writing of the determination. The Coordinator shall offer the Employee a leave of absence (paid, if the Employee has available leave, or unpaid, in all other cases) as a Reasonable Accommodation.

viii. If the Employee disagrees with the Coordinator's determination, he or she may appeal in writing to the Director within seven calendar days of the notice of determination. The Director's decision regarding a requested accommodation is final.

ix. If the Modified Work or Alternative Work assignment exceeds six months, or if the Coordinator and/or department knows or believes that the Employee requires a permanent or long-term Reasonable Accommodation, or if the Coordinator and department disagree over how a request for Temporary or Short-term Reasonable Accommodation should be handled, then the Coordinator will transfer the request to the Committee for consideration.

Responsible Persons: Employee / Department Management / Coordinator / Human Resources Director

b. Permanent or Long-Term Disability.

i. An Employee with a Permanent or Long-Term Disability who believes that he or she is in need of a Reasonable Accommodation may notify his or her direct supervisor of the need orally or in writing. Please note that Workers' Compensation staff will coordinate this process for Employees with industrial injuries, and provide the necessary medical certification information.

ii. Upon receiving such oral or written notice, the Employee's supervisor will notify the Coordinator of the request for Reasonable Accommodation. The Coordinator will contact the Employee, direct him or her to this Administrative Instruction with the attached forms, and assist the Employee through the Interactive Process as necessary.

iii. The Employee must complete the Employee Request for Permanent or Long-Term Reasonable Accommodation form (Forms F) and submit it to the Coordinator.

iv. Within fourteen calendar days of submitting the Request for Permanent or Long-Term Reasonable Accommodation form to the Coordinator, the Employee must submit a certification of Disability from a Health Care Provider, certifying that the Employee has a Disability and listing the permanent or long-term work restriction(s) associated with the Disability. The Employee can use the Medical Certification form (Forms C) or a written communication from a Health Care Provider to satisfy this requirement. The Coordinator may extend the time to submit a certification beyond fourteen calendar days if the certifying Health Care Provider requires additional time to prepare the certification.

v. Upon receipt of the form and certification, and an Essential Functions Job Analysis for the Employee's current job classification, indicating the traditional physical, mental, and emotional requirements for that classification, the Coordinator will schedule a meeting between the Employee and the Committee. The Coordinator shall provide the Employee with written notice of the date and time of the meeting.

vi. The Committee and Employee shall meet and review the Employee's work restriction(s) and discuss options for providing Reasonable Accommodation. It may take one or more meetings to fully explore all possible Reasonable Accommodation options.

vii. At the conclusion of such meeting(s), the Committee may:

(a) Approve the request for Reasonable Accommodation. If the Committee has agreed that the Employee can perform all essential functions of his or her job classification with the same efficiency and effectiveness, the requested accommodation does not place an undue hardship on the department or on the City, and the accommodation does not pose a direct threat to the Employee, his or her coworkers, or the general public, the Employee's request for a Reasonable Accommodation will be approved and the Employee will be provided with Modified Work; or

(b) Identify options for placement into Alternative Work. If the Committee determines that Reasonable Accommodation is not possible, the Committee will discuss with the Employee options for pursuing Alternative Work. Under Alternative Work, an Employee can transfer into an unfilled approved vacancy at the City so long as the Employee meets the minimum qualifications for the position, is able to perform the essential functions of the position with or without reasonable accommodation, the salary for the new position is equal to or less than the employee's current classification's salary, and such an assignment does not contravene a memorandum of understanding between the City and a bargaining unit. Employees placed in permanent full or part-time positions through Alternate Work will serve a probationary period in the new assignment. Further, Employees will be compensated at the rate of the newly assigned classification.

viii. Meeting notes will be taken at all Committee meetings, which shall detail the discussion that took place, identify any agreements reached, and any outstanding items that may need further review or action. The Coordinator shall provide a copy of the meeting notes to the Employee. The Coordinator shall notify the Employee in writing of any Committee decision(s).

c. Appeal Process.

i. Employees Vested in CalPERS.

(a) If the Committee determines that Reasonable Accommodation is not possible, the Coordinator shall notify the Employee in writing of the Committee's determination and advise the Employee that the City intends to file an application for Disability retirement with CalPERS on the Employee's behalf.

(b) If the Employee disagrees with the Committee's determination, he or she may file a written appeal of the determination to the Director within fourteen calendar days of the Coordinator's notice. If the Employee does not file a written appeal within fourteen calendar days, he or she will be deemed to have waived his or her right to appeal.

(c) The Director shall consider the Employee's timely written appeal. If the Director upholds the appeal, the Committee shall reconsider its determination. If the Director denies the appeal, if the Employee fails to timely appeal, or if the Employee waives his or her right to appeal, the City shall place the Employee on a leave of absence (paid, if the Employee has available leave, or unpaid, in all other cases) while CalPERS makes a decision on the application for Disability retirement.

(d) If the Employee is not Disability retired with CalPERS, whether through a determination by CalPERS or by the Employee's choice, and if accommodation remains unreasonable or is not possible, then the Appointing Authority shall send a Notice of Intent to Separate to the Employee.

(e) If the Employee believes that separation is not appropriate, he or she may respond orally or in writing to the Appointing Authority within five calendar days of the date on the Notice of Intent to Separate. If the Employee does not respond timely, he or she will be deemed to have waived his or her right to a pre-termination meeting with the Appointing Authority prior to his or her decision.

(f) If the employee requests a pre-termination meeting, the Appointing Authority shall consider the Employee's arguments and written submissions, if any. If the Appointing Authority finds that compelling new medical or other information might support the Employee's return to work, the Appointing Authority shall refer the request to the Committee for further consideration.

(g) If the Appointing Authority believes that accommodation is unreasonable or not possible, the Appointing Authority shall send a Notice of Decision to Separate to the Employee.

(h) The Employee may appeal this decision to separate to the City's Personnel Board, as provided in the Santa Monica Municipal Code. The Personnel Board's decision is final.

ii. Permanent Employees Not Vested in CalPERS.

(a) If the Committee determines that Reasonable Accommodation is not possible, the Coordinator shall notify the Employee in writing of the Committee's determination.

(b) If the Employee disagrees with the Committee's determination, he or she may file a written appeal of the determination to the Director within fourteen calendar days of Coordinator's notice. If the Employee does not file a written appeal within fourteen calendar days, he or she will be deemed to have waived his or her right to appeal.

(c) The Director shall consider the Employee's timely written appeal. If the Director upholds the appeal, the Committee shall reconsider its determination. If the Director denies the appeal, if the Employee fails to timely appeal, or if the Employee waives his or her right to appeal, the Appointing Authority shall send a Notice of Intent to Separate to the Employee.

(d) If the Employee believes that separation is not appropriate, he or she may respond orally or in writing to the Appointing Authority within five calendar days of the date on the Notice of Intent to Separate. If the Employee does not respond timely, he or she will be deemed to have waived his or her right to a pre-termination meeting with the Appointing Authority prior to his or her decision.

(e) If the employee requests a pre-termination meeting, the Appointing Authority shall consider the Employee's arguments and written submissions, if any. If the Appointing Authority believes that compelling new medical or other information might support the Employee's return to work, the Appointing Authority shall refer the request to the Committee for further consideration.

(f) If the Appointing Authority finds that accommodation is unreasonable or not possible, the Appointing Authority shall send a Notice of Decision to Separate to the Employee.

(g) The Employee may appeal this decision to separate to the City's Personnel Board, as provided in the Santa Monica Municipal Code. The Personnel Board's decision is final.

iii. Probationary Employees Not Vested in CalPERS.

(a) If the Committee determines that Reasonable Accommodation is not possible, the Coordinator shall advise the employee verbally of such decision. A written notice will follow that same day via e-mail or the United States Postal Service.

(b) If the Employee disagrees with the Committee's determination, he or she may file a written request for review of the determination to the Director within five calendar days of the Coordinator's notice. If the Employee does not file a written request within five calendar days, he or she will be deemed to have waived his or her right to request a review.

(c) The Director shall consider the Employee's timely written request for review. If the Director finds that compelling new medical or other information might support the Employee's return to work, the Director shall refer the request to the Committee for further consideration.

(d) If the Director finds that accommodation is unreasonable or not possible, the Appointing Authority shall follow the City stated policies for separating Probationary Employees.

Responsible Persons: Employee / Coordinator / Committee / Human Resources Director / Appointing Authority / Personnel Board

B. Perception of an Employee as Disabled

1. If any supervisor perceives or believes that an Employee may be in need of Reasonable Accommodation for a Disability, or that the Employee may be a safety risk to himself or herself, or to other employees, or to the public, or is unable to perform one or more of the Employee's Essential Functions, the supervisor shall contact the Coordinator to determine if engaging in the Interactive Process with the Employee is appropriate.

2. If appropriate, at the request of the Appointing Authority, the Director shall schedule a fitness for duty examination to determine if the Employee has a Disability that: (i) impacts his or her ability to perform the Essential Functions of his or her classification and it is unclear if a reasonable accommodation is possible; or (ii) poses a direct threat to the Employee, other employees, or the public.

3. If the Health Care Provider certifies that an Employee is Disabled, the City will provide the Employee with the appropriate process as described in this Administrative Instruction.

Responsible Persons: City supervisor, manager or other employer representative / Coordinator

VI. Forms

A. Applicant Request for Reasonable Accommodation Form
B. Employee Request for Temporary/Short-Term Reasonable Accommodation Form
C. Medical Certification Form
D. Temporary Modified/Alternative Duty Agreement Form
E. Temporary/Short-Term Reasonable Accommodation Decision Form
F. Employee Request for Permanent/Long-Term Reasonable Accommodation Form

VII. Authorized By

_____
Rod Gould
City Manager

City of Santa Monica

FORM A

APPLICANT REQUEST FOR REASONABLE ACCOMMODATION FORM

To request a reasonable accommodation for an examination, please complete the following form and submit it, along with medical certification from a health care provider, to the Human Resources Department at least three working days prior to the examination. If the accommodation request involves wheelchair access or sitting in the front of the room, it is not necessary to complete this form or advise the Human Resources staff in advance of the examination.

NAME:_____ EMPLOYEE ID#:_____
(Last/First/Middle)
ADDRESS:_____

CITY:_____ STATE: _____ ZIP CODE:_____

TELEPHONE: Work: (___) -_____ Home: (___) -_____

POSITION APPLIED FOR:_____
(Classification Title)

Please respond to the following:

My disability impairs my ability to accurately exhibit my knowledge and skill on the examination in the following manner:

_____
_____

The reasonable accommodation(s) I am requesting is:

- ☐ Separate testing area (This is required if there will be verbalization either by the applicant or by the reader/recorder.)
- ☐ Sign language interpreter
- ☐ Large print materials
- ☐ Written instructions as accommodation for hearing impairment
- ☐ Reader
- ☐ Scribe
- ☐ Specified breaks during testing (Also available for lactating mothers)
- ☐ Additional Testing Time (Specify) _____
- ☐ Special Chair/Table (Specify) _____
- ☐ Special Lighting (Specify) _____
- ☐ Other (Specify) _____

COMMENTS:_____
_____
_____

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I certify that I agree to the modified testing condition(s) authorized by the City and I will not discuss the exam content with anyone other than authorized representatives of the City. I give permission for the City to contact my health care provider to verify my need for testing accommodations or to discuss my work restrictions, if necessary.

_____ _____
Signature Date

City of Santa Monica

FORM B

EMPLOYEE REQUEST FOR TEMPORARY/SHORT-TERM REASONABLE ACCOMMODATION FORM

To request temporary/short-term reasonable accommodation(s), please complete and submit this form to the Accommodation Committee Coordinator in Human Resources. If you need assistance completing this form, please contact Human Resources.

NAME:_____EMPLOYEE ID#:_____
(Last/First/Middle)

TELEPHONE: Work: (_____) -_____ Home: (_____) -_____

CURRENT CLASSIFICTION:_____

WORK LOCATION:_____
(Address)

I am requesting Temporary/Short-Term accommodation for the following work restrictions (Attach Medical Certification Form completed by your health care provider*):

_____
_____
_____

I am requesting the following reasonable accommodation(s):

_____
_____
_____

Additional Comments:

_____
_____
_____

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I give permission for the City to contact my health care provider to verify my work restrictions, if necessary.

_____ _____
Signature Date

*Attach Medical Certification Form from your health care provider listing the type and duration of all work restrictions. Please do not include any information relating to your diagnosis or medical condition.

City of Santa Monica

FORM C

MEDICAL CERTIFICATION FORM

Patient/Employee Name: _____ Job Title: _____

Industrial Injury: Yes ☐ No ☐ Date of Injury: _____ Exam Date: _____

The above employee has been under my care since _____ (Date)

PATIENT'S STATUS

Please indicate **ALL** that apply:

☐ Job Analysis or Job Description has been reviewed and taken into consideration.
☐ Return to Work with **NO RESTRICTIONS** on _____ (Date) Follow up visit _____ (Date)
☐ Return to Work **WITH RESTRICTIONS**** starting _____ (Date) **thru** _____ **(Date)**
☐ Restrictions are **TEMPORARY** through _____ (date) ☐ Restrictions are **PERMANENT**
☐ **TAKEN OFF WORK** starting _____ (Date) thru _____ (Date)
☐ Next Appointment Date: _____

WORK RESTRICTIONS ****check all that apply**

☐ NO repetitive lifting/carrying of _____lbs. or more
☐ NO lifting/carrying of _____lbs. or more
☐ NO repetitive pushing/pulling of _____lbs. or more
☐ NO pushing/pulling of _____ lbs. or more
☐ NO at or above shoulder level reaching
☐ NO repetitive keyboarding in excess of ____mins per hr
☐ NO prolonged walking in excess of ____minutes
☐ NO repetitive bending / stooping
☐ NO repetitive squatting / kneeling
☐ NO prolonged standing in excess of ___min.
☐ NO prolonged sitting in excess of ___min.
☐ Must alternate sitting/standing
☐ NO running / jumping / climbing
☐ Other (please be specific):_____

Additional Physician Restrictions:

_____ _____
Physician's Original Signature Date

PLEASE PRINT:

Physician's Name: _____ CA Lic #:_____
Address: _____
Phone: (____)_____Fax: (____)_____

City of Santa Monica

FORM D

TEMPORARY MODIFIED / ALTERNATE DUTY AGREEMENT

Employee Name:

Classification/ Job Title:

Location:

Date of Injury/ Onset of Illness:

Date Assigned to Temporary Light Duty by Physician:

Light Duty Start Date: **Light Duty End Date:**

Description of Work Restrictions, per Treating Physician: (List specifically what is stated in medical note.)

Assignment Type Offered: ☐ **Modified** ☐ **Alternate/ Description of Accommodation(s) Offered:**

Work Schedule: ☐ **Unchanged** ☐ **Changed:** **Work Hours per Day from** **am/pm to** **am/pm**

Assigned Supervisor's Name, if Different:

Assignment Not Available. Reason/Discussion Points:

I agree to follow the work restrictions as prescribed above by my treating physician. I understand that I need to adhere to the agreed upon temporary restrictions and accommodations, and that the City of Santa Monica may have to end this assignment or take appropriate administrative action if I do not. I also understand that if I am asked to perform any work assignments or activities that exceed my work restrictions, I will immediately report the situation to my direct supervisor and Risk Management/Human Resources, and that I will not perform these activities. Furthermore, I will immediately report to my direct supervisor and to Risk Management/Human Resources if any of the work restriction(s)/accommodation(s) cause me discomfort or make my medical condition worse.

I understand that a temporary modified/alternate duty assignment typically will not normally exceed a maximum of 180 days, contingent upon approval at intervals not to exceed 45 days, and does not confer entitlement to a permanently modified position. I also understand that it is my responsibility to provide my direct supervisor and/or Risk Management/Human Resources with a new medical notice at the conclusion of the initial approval period and if I fail to do so I will be removed from my temporary assignment. I understand that this approval period ends and will not be extended unless I provide additional needed medical certification and unless there is a necessary assignment for me to perform that is within my restrictions.

RM/HR Signature: _____ **Date:** _____

Employee's Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Additional Comments/Notes:

_____

_____

City of Santa Monica

FORM E

TEMPORARY / SHORT-TERM
REASONABLE ACCOMMODATION DECISION FORM
UNABLE TO ACCOMMODATE

Date: _____

Name: _____ Classification: _____

Dept/Division: _____

Name/Title of person completing form:_____

1. What action initiated the need for a temporary / short-term reasonable accommodation assessment?

   ☐ Request by employee due to physical/mental limitations
   ☐ Employer perception of employee as potentially in need of reasonable accommodation

2. List the work restrictions that the employee has that are in need of accommodation:

   Medical report by: Dr. _____

   Date of Medical Report: _____

   Work Restrictions (list all):

   _____
   _____
   _____
   _____

   Restricted through the following date: _____

3. Can the employee/candidate perform the essential functions without an accommodation?
   ☐ Yes ☐ No

4. What essential functions can the employee/ candidate not perform without an accommodation? List specific essential functions or job duties that are unable to be performed due to the work restrictions listed above. Attach sheet if additional space is required.

   _____
   _____
   _____
   _____
   _____

5. List all meetings where you met with the employee to discuss their temporary accommodation needs:

   Date: Discussion Summary:

   _____
   _____
   _____
   _____
   _____

6. Have you contacted the Job Accommodation Network (JAN) at (800) 232-9675, for suggestions (maintain names & dates)?

   Notes:

   _____
   _____
   _____
   _____
   _____

7. Have other employees/candidates with similar limitations been accommodated in the same type of job in question? Please explain:

   _____
   _____
   _____
   _____
   _____
   _____

8. Please refer to the essential functions listed in #4 above. List and review each essential function separately. Use additional sheets to explain your answer.

A. **Essential Function**: _____

Have the following items been considered? Please circle, circle N/A if not applicable.

a.	Worksite modification to allow accessibility	Yes	No	N/A
b.	Job restructuring	Yes	No	N/A
c.	Modified work schedule	Yes	No	N/A
d.	Flexible leave policy	Yes	No	N/A
e.	Reassignment to vacant position in the same class within department	Yes	No	N/A
f.	Modification of existing equipment or devices	Yes	No	N/A
g.	Acquisition of assistive equipment or devices.	Yes	No	N/A
h.	Assignment of personal assistant, qualified reader or interpreter	Yes	No	N/A
i.	Adjustment or modification of training	Yes	No	N/A
j.	Assistive equipment or devices owned by employee/candidate	Yes	No	N/A
k.	Other accommodation(s) considered: _____			

Proposed Accommodation: _____

B. **Essential Function**: _____

Have the following items been considered? Please circle, circle N/A if not applicable.

a.	Worksite modification to allow accessibility	Yes	No	N/A
b.	Job restructuring	Yes	No	N/A
c.	Modified work schedule	Yes	No	N/A
d.	Flexible leave policy	Yes	No	N/A
e.	Reassignment to vacant position in the same class within department	Yes	No	N/A
f.	Modification of existing equipment or devices	Yes	No	N/A
g.	Acquisition of assistive equipment or devices.	Yes	No	N/A
h.	Assignment of personal assistant, qualified reader or interpreter	Yes	No	N/A
i.	Adjustment or modification of training	Yes	No	N/A
j.	Assistive equipment or devices owned by employee/candidate	Yes	No	N/A
k.	Other accommodation(s) considered: _____			

Proposed Accommodation: _____

C. **Essential Function**: _____

Have the following items been considered? Please circle, circle N/A if not applicable.

a.	Worksite modification to allow accessibility	Yes	No	N/A
b.	Job restructuring	Yes	No	N/A
c.	Modified work schedule	Yes	No	N/A
d.	Flexible leave policy	Yes	No	N/A
e.	Reassignment to vacant position in the same class within department	Yes	No	N/A
f.	Modification of existing equipment or devices	Yes	No	N/A
g.	Acquisition of assistive equipment or devices.	Yes	No	N/A
h.	Assignment of personal assistant, qualified reader or interpreter	Yes	No	N/A
i.	Adjustment or modification of training	Yes	No	N/A
j.	Assistive equipment or devices owned by employee/candidate	Yes	No	N/A
k.	Other accommodation(s) considered: _____			

Proposed Accommodation: _____

I certify that the above is true and correct assessment of providing reasonable accommodation for employee's job related restrictions (sign and date).

_____ ___ _____

Accommodations Committee Coordinator Date Department Head or Designee Date

Date of Meeting with employee: _____

Brief Summary of meeting:

_____

_____

_____

_____

City of Santa Monica

FORM F

EMPLOYEE REQUEST FOR PERMANENT/LONG-TERM REASONABLE ACCOMMODATION FORM

To request Permanent/Long-Term reasonable accommodation(s), please complete and submit this form to the Accommodation Committee Coordinator in Human Resources. If you need assistance completing this form, please contact Human Resources.

NAME:_____EMPLOYEE ID#:_____
(Last/First/Middle)

TELEPHONE: Work: (___) -_____ Home: (___) -_____

CURRENT CLASSIFICTION:_____

WORK LOCATION:_____
(Address)

I am requesting accommodation for the following work restrictions (Attach Medical Certification Form completed by your health care provider*):

_____
_____
_____

I am requesting the following reasonable accommodation(s):

_____
_____
_____

Additional Comments:

_____
_____
_____

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I give permission for the City to contact my health care provider to verify my work restrictions, if necessary.

_____ _____
Signature Date

*Attach Medical Certification Form from your health care provider listing the type and duration of all work restrictions. Please do not include any information relating to your diagnosis or medical condition.