SANTA BARBARA CITY COLLEGE

Human Resources

MEDICAL VERIFICATION FOR DISABILITY ACCOMMODATION CONSIDERATION

TO: Treating Physician or Practitioner

Our employee, _____, has informed us that you are treating him/her for a serious medical condition which may be considered a disability.

As a condition of requesting an accommodation for a serious health condition, the employee must have his/her physician provide medical verification of this disability. For our mutual convenience, please complete this standardized form. This information must be returned before the interactive process with the employee can begin.

1. Employee's Job Title: _____
2. Date of Most Recent Physical Examination: _____
3. With respect to your understanding as to what are the employee's essential job functions, please check the source(s) where you received your information:

   _____ College job description
   _____ Discussion with the employee's supervisor
   _____ Discussion with the employee

Please indicate the exact restrictions AND duration that these limitations will be in place for the employee. Please provide sufficient information regarding the impairment and the barrier there may be in performing the essential functions of the job.

What functional limitations is the employee experiencing relative to their job?

How to the limitations affect their job performance?

What specific job tasks are problematic?

Physical Limitations	Full Restrictions/ Duration	Partial Restrictions/ Duration	No Restrictions
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs.)			
Physical Limitations	**Full Restrictions/ Duration**	**Partial Restrictions/ Duration**	**No Restrictions**
Standing (hrs.)			
Sitting (hrs.)			
Stooping (hrs.)			
Kneeling (hrs.)			
Repeated Bending (hrs.)			
Climbing (hrs.)			
Operating a motor vehicle, crane, tractor, etc.			
Exposure Limitation (Specify)			
OTHER LIMITATIONS (specify**)**			

I hereby certify that the foregoing facts are true and correct, and are executed under penalty of perjury in _____, California this _____ day of _____ , 20__ .

_____ _____

* Signature of Treating Physician or Practitioner Date

_____ _____

Print/Stamp Name of Treating Physician or Practitioner Phone Number

_____ _____

Address of Treating Physician Fax Number

* "Treating Physician or Practitioner" is intended to mean Primary Care Physician, Urgent Care Physician, Emergency Room Physician, Physician's Assistant, Specialist, etc.