

**COUNTY OF SANTA CLARA  
POLICY AND PROCEDURE  
FOR  
REASONABLE ACCOMMODATION**

**I. POLICY**

It is the policy of the County of Santa Clara to fully comply with the reasonable accommodation requirements set forth in the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, California's Fair Employment and Housing Act (FEHA), and other related state and federal statutes. These laws require employers to provide reasonable accommodation to qualified employees and applicants with disabilities, unless the accommodation would cause an undue hardship.

The County of Santa Clara is committed to providing reasonable accommodations to employees and applicants in order to ensure that individuals with disabilities enjoy full access to equal employment opportunities. The County of Santa Clara will process requests for reasonable accommodation and, where appropriate, provide reasonable accommodations in a prompt, fair, and efficient manner.

Significant to the policy is the requirement that an employer engage in an interactive process with an employee or applicant in order to identify reasonable accommodation. The purpose of the interactive process is to identify the limitations resulting from disability and potential reasonable accommodations that could overcome those limitations.

Retaliation against an individual for requesting a reasonable accommodation is prohibited. Information obtained in this process will be confidential and limited to those with a need to know.

**II. REQUESTS FOR REASONABLE JOB ACCOMMODATION**

- A. A request for reasonable accommodation is a statement that an employee or applicant needs an adjustment in the application process, work place, work assignment, or in the terms or conditions of employment for a reason related to a disability or medical condition. An individual may request a reasonable accommodation as necessary, even if he or she has not previously disclosed the existence of a disability or medical condition.
- B. Requests for Reasonable Accommodation can be made either verbally or in writing by:
  - 1. **An applicant.** The applicant addresses a request to the person the applicant has contact with in connection with the application process for employment.

2. **An employee.** The employee addresses the request to his or her supervisor, another supervisor or manager in his or her immediate chain of command, departmental Health Injury Prevention (HIP) Coordinator, Departmental/ Agency Equal Opportunity Officer/ Advisor, and/ or to the Coordinator of Programs for the Disabled.
  3. **A Family member, health professional, Worker's Compensation Division Representative, or other representative** on behalf of an employee or applicant. The request is addressed to the appropriate department/agency contact as identified in #1 or #2 above.
- C. A manager or supervisor, who is aware of a work performance issue that may be related to a known or obvious disability, is to initiate discussion with the employee regarding possible need for accommodation and advise employee of the Policy and Procedures for Reasonable Accommodation.

### **III. PROCEDURES FOR REQUESTING REASONABLE ACCOMMODATION**

#### **A. Completion of Reasonable Accommodation Request Form**

Once a need for accommodation is identified, a "Reasonable Accommodation Request Form" must be completed. A copy of this form is attached as Form A. The Reasonable Accommodation Policy and Procedures and forms may be obtained from: (1) the Equal Opportunity Division (EOD) located at 2310 N. First St., Suite 101, San Jose 95131, (2) the department's Equal Opportunity Officer/ Advisor, or (3) the department/agency's employee service center.

1. **Applicants:** Applicants with a disability who are in need of accommodation(s) for employment consideration, must request accommodation by contacting the Human Resources Department at least one week prior to the date the accommodation is needed. A request for accommodation may be required for each stage of the hiring process. *For example, a hearing-impaired person may need an accommodation for the testing process and again for the hiring interview.*
2. **Employees:** Employees who are seeking reasonable accommodation must submit a copy of his or her work capacities and restrictions to his or her immediate supervisor. The manager/ supervisor shall forward a copy of the Request, Form A, to the Coordinator of Programs for the Disabled. Employees, who do not provide information from their medical provider concerning their work restrictions, will not be eligible to move forward in the process for reasonable accommodation consideration.
3. **Managers/Supervisors:** Managers/ supervisors request the employee to complete and return the Reasonable Accommodation Request Form A with required information on any work restrictions. The manager/ supervisor shall forward a copy of the completed Form A to the Coordinator of Programs for the Disabled, and the department/agency's Equal

Opportunity Officer/Advisor. Employees who do not provide the required information concerning their work restrictions from their medical provider, will not be eligible to move forward in the process for reasonable accommodation consideration.

## **B. Identification of Possible Reasonable Accommodation(s) for Employees**

1. Meeting With Employee: The manager/supervisor who receives a request for accommodation shall arrange to meet with the employee within ten (10) working days from receipt of the request.
2. Identification of Essential Functions: In preparation for the meeting with the employee to discuss possible accommodations, the manager/supervisor must identify the essential functions of the position that the employee currently occupies.

For assistance in identifying the “essential functions” of a particular position, managers/supervisors should refer to Section VI, “Definitions of Key Terms”, and Section VII, “Guidelines in Determining Essential Functions and Reasonable Accommodation.” For further guidance and information, please contact your departmental Equal Opportunity Officer/Advisor, or the Coordinator of Programs for the Disabled.

3. Identification of Potential Accommodations: The manager/supervisor and employee shall meet and discuss possible accommodations that would permit the employee to perform the essential functions of his or her job. The process includes consulting with the employee to determine his or her abilities and needs, identifying potential accommodations with the employee, and selecting the most appropriate accommodation. The manager/supervisor will discuss with the employee the specific limitations the disability imposes on the performance of the essential functions in order to identify a possible accommodation. More than one meeting may be required.

If it is determined that additional information or clarification of existing work restrictions and related information is needed, the employee is expected to obtain that information from his or her licensed health care provider within thirty (30) days from date of the request or meeting.

## **IV. DETERMINATION OF ACCOMMODATION**

Within twenty (20) working days after completion of the interactive process outlined in section III above, the manager/supervisor must make a determination as to whether an accommodation can be provided. Based on the determination, one of the following must be initiated:

### **A. Employee Can Be Accommodated**

If the employee can be accommodated in his or her current position or work unit, the manager/supervisor must: (1) put the accommodation into effect, and (2) complete and forward a copy of Form B (attached) to individuals referenced in the distribution list on the form.

The manager/supervisor is responsible for reviewing and evaluating the effectiveness of the accommodation(s) provided.

B. Unable to Accommodate Employee in His or Her Position or Work Unit

If the employee cannot be accommodated in his or her current position or work unit, the manager/supervisor must (1) complete and forward a copy of Form B, to those named on the distribution list of the form, and (2) contact the departmental/agency Equal Opportunity Officer/Advisor, and/or the departmental HIP Coordinator, in order to identify possible accommodations within the department/agency. The manager/supervisor or department designee shall notify the employee in writing that their request for accommodation has been forwarded to the department's Equal Opportunity Officer/Advisor, or to the department designee, for review and consideration for accommodation in the department/agency. If the employee can be accommodated elsewhere in the department/agency, follow Section IV, (A).

C. Unable to Accommodate Employee in Department/Agency

If the employee cannot be accommodated within the department/agency, the departmental Equal Opportunity Officer/Advisor, or the HIP Coordinator, is to notify the Coordinator of Programs for the Disabled, using Form B and is to provide appropriate documentation to include all positions considered and reasons why employee could not be accommodated. The Equal Opportunity Division will notify the employee in writing that his or her accommodation request has been referred to the Equal Opportunity Division for possible accommodation to another department/agency position.

D. Unable to Accommodate Employee in Any County Position

If it is determined that no reasonable accommodation is available within any County department or agency, the Equal Opportunity Division will notify the employee in writing of the inability to reasonably accommodate, and his or her right to have the decision reviewed by the Director of the Equal Opportunity and Employee Development Division.

V. **REVIEW PROCEDURE - ACCOMMODATION NOT AVAILABLE**

An employee seeking a review of no reasonable accommodation determination must submit a request for review to the Equal Opportunity Director within ten (10) working days of receipt of notification of inability to accommodate.

Within ten (10) working days of a request for review, the Director of Equal Opportunity will review the determination that reasonable accommodation is not available, and will take one of the following actions:

- A. Refer the employee's request for accommodation back to the Coordinator of Programs for the Disabled for further consideration. The employee will be notified in writing of this action.

OR

- B. Notify the employee and the appropriate departmental/agency representatives, and Labor Relations, in writing that no reasonable accommodation is available that meets the employee's work restrictions and work capacities.

## **VI. DEFINITION OF KEY TERMS**

**Disability:** A disability is in part a physical or mental impairment or disorder that limits a major life activity that affects the physical, mental, social activities and/or work of an individual.

**Essential Functions:** The job duties that are so fundamental to the position that the individual holds, or desires to hold, that he or she cannot do the job without performing these duties. A function can be "essential" if, among other things, the position exists specifically to perform that function. (Section VII provides guidelines in identifying "Essential Functions".)

**Qualified Individual with a Disability:** An individual with a disability is qualified if he or she satisfies the requisite skill, experience, education, and other job-related requirements of the position; and that he or she can perform the essential functions of the position, with or without a reasonable accommodation.

**Reasonable Accommodation:** Any change or adjustment in the work environment or in the way things are customarily done that would enable a qualified individual with a disability to enjoy equal employment opportunities.

Examples of reasonable accommodations include but are not limited to:

1. Making existing facilities accessible;
2. Job restructuring;
3. Part-time or modified work schedules
4. Acquiring or modifying equipment;
5. Changing tests, training materials, or policies;
6. Providing qualified readers or interpreters;

7. Reassignment to a vacant position;
8. Permitting use of accrued paid leave or unpaid leave for necessary treatment;
9. Providing reserved parking for a person with a mobility impairment; and
10. Allowing an employee to provide access or assisted equipment or devices that an employer is not required to provide.

**Reassignment:** Reassignment is a form of reasonable accommodation that, absent undue hardship, is provided to employees (not applicants) who because of a disability, can no longer perform the essential functions of their job, with or without reasonable accommodation. Reassignments are made only to vacant positions for employees who are qualified for the new position.

**Undue Hardship:** Undue hardship is an action requiring significant difficulty, or expense. Determination of undue hardship is always made on a case-by-case basis considering various factors including the nature and cost of the reasonable accommodation and the impact of the reasonable accommodation on the operations of the agency.

## **VII. GUIDELINES IN HOW TO IDENTIFY ESSENTIAL FUNCTIONS AND A REASONABLE ACCOMMODATION**

### **Consider all of the following factors:**

- 1) The function(s) are required to be performed by all persons in the position.
- 2) The position exists to perform the function.
- 3) Functions to be performed in the position, and the class specification and job bulletin for the position.
- 4) The number of other employees that are available to perform the function(s).
- 5) The expertise and skill required to perform the function(s).
- 6) The time spent performing the function(s).
- 7) Whether the position would be fundamentally altered if the function(s) were eliminated.
- 8) The essential function(s) of the position.
- 9) The work experience of past or current employees.
- 10) Terms of a collective bargaining agreement that may apply.

**While most managers/supervisors may not be experts on this matter, the following is a four-step process in how managers/supervisors can assess reasonable accommodation:**

1. Identify barriers to performance. Ask the person with the disability to clearly identify which job tasks are difficult because of the disability or limitations. If the disability limitations relate to non-essential functions, these may be reassigned to other employees or eliminated from the job. Any problems with performing essential functions can then be addressed.
2. Identify possible accommodations. There are many resources available for developing accommodations, including: (1) the employees themselves, (2) other managers/supervisors, (3) worker's compensation, or (4) personnel staff. Contact the Equal Opportunity Division for further resources at 408-993-4840.
3. Assess the reasonableness of each accommodation. There may be several different accommodations that will enable the employee to perform his or her job. There is no requirement to choose the most elaborate or expensive accommodation, but instead to choose the "most effective" one, even if it is less expensive. Evaluate individual accommodations by considering the following questions:
  - a. Does the accommodation enable the person to perform the essential function(s) of the job to the employer's "normal standards"? An accommodation that does not allow the person to perform at full productivity may not be a good alternative.
  - b. Does the accommodation appear to be reliable and capable of being provided in a timely manner?
  - c. Does the accommodation enable the person with a disability to be competitively employed and to have equal advancement and promotional opportunities?
4. Choose an appropriate reasonable accommodation. Given the criteria above, consider which accommodation is most effective. NOTE: if an accommodation is not considered or denied due to the expense of the accommodation, the Coordinator of Programs must review the denial for the Disabled.

Attachments: FORM A: Employee Request for Reasonable Accommodation  
FORM B: Department Response to Request for Reasonable Accommodation

# County of Santa Clara Form A



## Employee Request for Reasonable Accommodation (To be completed by Employee)

The County of Santa Clara encourages use of this form by individuals requesting a reasonable accommodation of a disability or medical condition. If you have not completed the form, your supervisor or manager will ask you to complete it to assist the County in evaluating your request.

**NOTE:** Current medical documentation from a licensed health care provider, other health professional, or counselor that details your physical/mental limitations, capacities or restrictions, may be required and should be submitted. If it is required and not submitted, your request may not be eligible to move forward in the assessment process and a final determination cannot be made.

Employee Name:	Classification/Job Title:	Employee ID #:
Work Location Address:	Work Telephone:	POD # (SSA Only)
Work Schedule:	Personal Telephone:	

Supervisor/Manager Name:	Department/Agency	Telephone:
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### **SECTION I:**

**A. What are your current limitations, (i.e. sleeping, walking, reading, working etc.) or work restrictions (i.e., unable lift more than # lbs.; unable to type for more than #minutes per hour; or unable to work during episodic flare ups, etc.) caused by your disability or medical condition/restrictions? You are not requested or required to disclose any diagnosis, disability or medical condition.**

**B. What are the specific job task(s) or duty (ies) that are more difficult as a result of the limitations/work restrictions you noted above? (Examples: all typing and computer work; all of my duties and responsibilities are affected by my limitations; unloading daily shipments, sleeping, walking, reading etc.)**

**C. What accommodation(s) are you requesting, (if known) and how will the accommodation help you with performing the job tasks or duties listed above. Be as specific as possible. (Examples: request alternative work schedule to allow a full day of work; request voice activated software which will limit my typing, allowing me to continue to complete computer duties, etc.) If this request is specific to accessibility, please contact the Equal Opportunity Department. NOTE: The Department may provide an alternative accommodation which they deem most effective.)**



# Employee Request for Reasonable Accommodation

Employee Name:	Classification/Job Title:	Employee ID #:
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D. Are the limitation(s) listed above:  Permanent -or-  Temporary- If temporary, what is the anticipated duration: \_\_\_\_\_. If you have both permanent and temporary limitations, list and specify each separately).

E. If you are requesting a leave, do you intend to return to work with the County of Santa Clara at the conclusion of your leave?  No  Yes

F. Is this request related to a Workers' Compensation (WC) claim?  No  Yes - If yes, provide:

Date of Injury: \_\_\_\_\_ WC Claim #: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_

## SECTION II:

Within 10 working days of making a request for accommodation, you will have an interactive discussion with a supervisor or manager regarding this request. The Department will provide you a final determination within 20 working days following the conclusion of the 'interactive' process.

Can you continue working without an accommodation until a final determination is made?  Yes  No  
(If not, the department may provide you a temporary accommodation, which may include an approved leave pending a final determination)

If you are unable to wait for a determination **because** the duration of your request will end within 20 working days, contact your department Reasonable Accommodation Coordinator **or** the County Equal Opportunity Department at (408) 993-4840 or [EOD@eod.sccgov.org](mailto:EOD@eod.sccgov.org)

## SECTION III:

I understand I am not required to disclose my diagnosis, disability or medical condition; but I certify that I have a disability or medical condition that requires a reasonable accommodation, as requested above.

I have provided medical documentation (attached) to support my request from:

Doctor Name: \_\_\_\_\_

Date of doctor's note: \_\_\_\_\_

Employee Signature:

Date of completion of this Form:

Date of Reasonable Accommodation Request:

\_\_\_\_\_



## County of Santa Clara Form B Response to Request for Reasonable Accommodation (To be completed by Manager/Supervisor)

This form is intended to document the Interactive Discussion(s) and final determination of an accommodation request.

**NOTE:** Prior to completing the following information you are required to engage in an interactive discussion with the employee as soon as possible but no later than **10 working days after receiving a request for accommodation**. More than one interactive discussion between you and the employee may be necessary to complete the request.

<b>Employee Name:</b>	<b>Employee ID #:</b>
<b>Employee Classification:</b>	<b>Employee Work Location Address:</b>
<b>Supervisor/Manager Name:</b>	<b>Supervisor/Manager Classification:</b>
<b>Supervisor/Manager Phone Number:</b>	<b>Area/Unit of Responsibility:</b>

- 1) Received the "request" or became aware of a need for an accommodation on: \_\_\_\_\_ (date)
- Verbal Request       Written Request       Personal Observation

**(NOTE:** If you did not receive a written request for accommodation, ask the employee to complete the Form A - Request for Accommodation. The Form A - Request for Accommodation Form or a written request **is not** mandatory. Therefore, **DO NOT DELAY** initiating the interactive discussion pending receipt of a written request.)

- 2) Multiple interactive discussions may be required and must be documented.  
List every date there was an interactive discussion with the employee regarding this accommodation request. Include who was present during the interactive discussion(s) and a summary of the discussion/s:

**(NOTE:** You are required to make a final determination whether an accommodation can be provided within 20 working days after completion of the interactive process/discussion(s).

- 3) Medical note received: Yes :  No :   
If yes, date on medical note: \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

4) Was there a clarification of medical note requested: Yes :  No :  Date Requested : \_\_\_\_\_

5) Is this Accommodation request related to a Workers' Compensation injury?:  No  Yes

Date of Injury \_\_\_\_\_ Claim # \_\_\_\_\_ Work. Comp. Adjuster \_\_\_\_\_

(NOTE: Check with Work Compensation to verify any other restrictions/limitations)

6) Does the employee's limitations/restrictions impact any "essential" function(s) as defined in the County's Reasonable Accommodation Policy/Procedure?

Yes  No

(Also see Section #2 under Note of this Form)

7) List all suggested accommodations you discussed with the employee (include those request by the employee, medical provider and department).

**ACCOMMODATION DECISION:**

Attach a copy of the job specification. List below only the essential job functions/duties, based on the job specification that are affected by this request, that you will or will not be accommodating.

Complete Section #1, for accommodations that are approved; or Section #2, for accommodations that are not approved. Complete both sections if applicable.

**SECTION #1** -  Accommodation is approved  Partially Approved

**If not approved, see below**

List all restrictions. For each, identify whether the restriction is permanent or temporary.

Start/Effective date of the accommodation: \_\_\_\_\_

If the accommodation is based on permanent restrictions, indicate when you will review effectiveness of the accommodation:

Accommodation will be reviewed on: \_\_\_\_\_ By (Print Name): \_\_\_\_\_

If the accommodation is based on temporary restrictions, indicate anticipated:

End date of accommodation: \_\_\_\_\_

Has this accommodation been provided for more than six (6) months: Yes:  No:   
**(If yes contact your RA coordinator or Equal Opportunity Advisor)**

**The department has agreed to the following accommodation(s):**

(For example: employee will self-modify in accordance with her doctor’s recommendations. Employee will notify their supervisor should there be job tasks/duties that require them to work beyond their limitations/restrictions. OR: Employees work hours or work duties will be modified as follows: (the information must be detailed without ambiguity.)

**SECTION #2**

The employee’s request for Accommodation is not approved. (Please refer to Reasonable Accommodation Policy/Procedure).

**You must consult with an Equal Opportunity Officer prior to completing this section.**

Consulted with Equal Opportunity Division:

Date \_\_\_\_\_ Consulted with EO Officer (Name): \_\_\_\_\_

Employee informed of approval/denial on (date): \_\_\_\_\_

Person who notified the employee (Please print Name/Classification): \_\_\_\_\_

Employee Refused the Accommodation (refer to County Policy)

Date of Refusal: \_\_\_\_\_

**NOTE: A denial of accommodation requires that one (or more) of the following circumstances apply. Check and complete the applicable section(s). (Specific details in support of your reason(s) is required)**

A) The accommodation the employee seeks requires “eliminating” the essential function(s) of:  
\_\_\_\_\_ (See guidelines below on essential functions)

AND a reasonable accommodation is not available that would enable the employee to perform this essential function.

B) Guidelines on determination of Essential Functions Check all that applies:

- The position exists to perform that function
- There are a limited number of employees available to perform the function, or among whom the function can be distributed.
- The function is highly specialized, and this employee was hired for his/her special expertise or ability to perform the function.
- The amount of time in terms of a daily percentage that is spent on the job performing the particular function on a “daily” basis is \_\_\_\_\_.
- The amount of time spent performing the function is slight, but the consequences of **NOT** performing the function are significant. The consequences of **NOT** requiring the

employee to perform the essential function of \_\_\_\_\_ is \_\_\_\_\_.

- Creates a significant negative impact on services provided
  - Creates Health and/or Safety issues
  - Unreasonable shifting of duties
- C)  Undue Hardship (explain in detail)  
(e.g. impacts other employees' ability to perform the essential functions of his/her position)

D)  Other (explain in detail)

E)  This is an essential function defined in the terms of a collective bargaining agreement (CBA)

CBA Name: \_\_\_\_\_

**(NOTE: If the department is unable to accommodate, you must contact your EO/RA Officer/Coordinator)**

**APPROVALS:** (At least two approval signatures are required. If you have a designated EO/RA Officer/Coordinator for your department, this must be forwarded and approved by the EO/RA Officer/Coordinator):

\_\_\_\_\_  
Print Name/Title Signature Date

\_\_\_\_\_  
Print Name/Title Signature Date

Copy: Manager/Supervisor; Departmental EO Officer/Advisor; Equal Opportunity Division; and Department/Agency Head

The signature below signifies the Employee acknowledges receipt of a copy of this form and also agrees to inform the supervisor/manager at any time they believe that the accommodation provided is not effective, or that it should be changed, modified, or is no longer required.

Employee Name \_\_\_\_\_ Employee Signature \_\_\_\_\_ Date \_\_\_\_\_