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.

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

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 deta**il)**
(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** _____