SJSU SAN JOSÉ STATE UNIVERSITY

Building an Inclusive Workforce

EARC VERIFICATION FORM

Employment Accommodation Resource Center (EARC)
One Washington Square, San Jose, CA 95192-0046
P: (408) 924-6003 | F: (408) 924-4358 | TTY: (408) 924-5990

Please note: Pursuant to Title II of the Genetic Information Nondiscrimination Act of 2008 (GINA) do 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. This form is to request information pertaining to the Americans with Disabilities Act as Amended of 2008, (ADAAA) and California's Fair Employment and Housing Act (FEHA).

For general questions or to obtain clarification about the information requested on this form, please contact EARC at (408) 924-6003.

Verification requested for: _____
Employee/Patient Name: (Last, First, M.I.)

Length of time this patient has been under your care: _____

1. Under California's Fair Employment and Housing Act (FEHA), an individual with a disability is one who:
   a) Has a physical or mental condition that limits a major life activity (see table below for information); or,
   b) Has a record or history of a physical or mental condition.

Does the patient meet this definition?

☐ Yes Proceed with questions.

☐ No Do not proceed with questions. Complete contact information on bottom of page three (3).

What major life activity(ies) do you believe is/are limited by the impairment? Please check level of limitation you believe this patient experiences as a result of the patient's impairment. Check only the boxes that apply.

1 = Unable to determine 2 = Mild 3 = Severe

Major Life Activity	Major Life Activity	Major Life Activity
Select Bending	Select Breathing	Select Caring for oneself
Select Communicating	Select Concentrating	Select Controlling bowels
Select Eating	Select Hearing	Select Interacting w/others
Select Learning	Select Lifting <lbs.	Select Performing manual tasks*
Select Reaching	Select Reading	Select Reproduction
Select Running	Select Seeing	Select Sexual functions
Select Sitting	Select Sleeping	Select Speaking
Select Standing	Select Thinking	Select Walking
Select Working		
Operation of major bodily functions†:		
Other: (please specify)		

* including household chores, bathing, brushing teeth

† including functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions

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2. List the patient's current limitations connected with their impairment:

3. What is the duration of the impairment? If not permanent, how long will the impairment likely last?

☐ Permanent

☐ Long-term _____
(approximate amount of weeks, months, or years)

☐ Temporary Begin: _____ End: _____

☐ Episodic Frequency of episodes: _____
(approximate no. per week, month, or year)

Is it medically necessary for patient to be absent from work during episodic flare-ups?

☐ No ☐ Yes Explain below:

4. Describe how the impairment limits the patient in performing their job duties. If the condition is episodic, describe how the impairment may impact the patient's job duties when limitations are active.

5. Provide any suggested accommodations for the patient and the medical rationale behind your suggestions. If the patient requires medical leave, would providing the requested amount of leave assist the patient to return to work and perform their essential job duties? What is the duration of the medical leave?

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6. In the absence of workplace accommodations(s), while performing their job duties would the patient post a direct threat to their safety, and/or safety of others in the workplace?

☐ No ☐ Yes

If yes, please explain the substantial harm and significant risk this may impose on the patient or others.

Certifying Licensed Physician or Primary Health Care Provider qualified in the appropriate specialty area.
(Must be completed by a licensed practitioner)

Name: (Last, First, M.I.) _____

Medical Facility: _____

Address _____

City _____

State: --SELECT-- ZIP: _____ Phone: _____

License no: _____ Specialty: _____

Signature: _____ Date: _____

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

For general questions pertaining to information requested, please contact the Employment Accommodations Resource Center at 408-924-6003.