State of California-Department of Fish and Wildlife
REASONABLE ACCOMMODATION REQUEST
DFW 261 (REV. 1/20/22) Page **1** of **2**

SAVE PRINT CLEAR

This document contains personal information and pursuant to Civil Code Section 1798.21 shall be kept confidential in order to protect against unauthorized disclosure. This information will only be used to determine the specific equipment and/or services necessary to consider a reasonable accommodation for qualified individuals with a disability.

A reasonable accommodation provides equal employment opportunity including a pre-employment examination, job interview, and to perform the essential functions of their job. For procedural information and policy compliance, refer to the *CDFW's Operations Manual section 12540 et seq.*

A request for a reasonable accommodation requires medical verification that meets the criteria below when the disability is not obvious. To ensure confidentiality, medical verification may be sent directly to:

Upon receipt, the department will engage in the *interactive process* promptly and in good faith to identify or implement an effective reasonable accommodation.

Human Resources Branch Employee Wellness Services Unit P.O. Box 944209 Sacramento, CA 94244-2090	Telephone and Confidential Fax: (916) 653-8120 (Phone) (916) 651-7515 (Fax)

MEDICAL VERIFICATION & REQUIREMENTS BY HEALTHCARE PROVIDER

The following medical verification and current duty statement are essential to determining an effective accommodation. Please do not include a diagnosis or genetic information:

A. Define the employee's work limitation and/or restriction.
B. Include a medical recommendation for reasonable accommodation.
C. Legible writing or computer generated on official letterhead or form of the Healthcare Provider or group organization.
D. Include the Healthcare Provider's professional credentials (M.D., R.N., etc.)
E. Include the date of the medical evaluation and the date the verification was written.
F. Signature of the Healthcare Provider (written or electronically generated)
G. Describe how the accommodation will enable the employee to perform the essential functions of the employee's job.
H. Define the duration of the work limitation and/or restriction (if temporary, an expected termination date is required).
I. If recommending a specific accommodation, please note CDFW does not waive its rights to an alternative solution.

EMPLOYEE'S INFORMATION

Name:(Please print or type)	Classification:	Work Phone:
Office/Division/Branch:	Work Location:	Reporting Unit/Section:

☐ Medical verification attached ☐ Medical verification sent to HRB's MDSU on _____

Identify whether the work limitation and/or restriction is permanent or temporary. If temporary, the duration for the accommodation is required.

☐ Permanent ☐ Temporary: Start Date _____ End Date _____

Distribution: 1. Employee (Copy) 2. Human Resources Branch (Original) 3. Supervisor (Copy)

Name:(Please print or type)	Classification:

Refer to the *CDFW Operations Manual section 12540* for description of the types of accommodations
Check the box for the Type of Accommodation Requested:

☐ Modifying Work Site ☐ Job Restructuring or Modifying ☐ Assistive Devices ☐ Support Services Assistants ☐ Personal Care Assistants ☐ Alternate Work Schedule	☐ Leave of Absence ☐ Reduced Work Schedule ☐ Alternative Job Placement (Unable to perform the essential functions of the job) ☐ Telecommuting (Ops. Manual section12240) ☐ Other (Describe below):

Briefly explain how this accommodation will provide you an equal employment opportunity and/or perform the essential functions of the job:

Employee Please provide Manager/Supervisor's Information

Manager/Supervisor: (Please type or print)	Work Phone:
Manager/Supervisor email	Date Submitted:
Employee's Signature:	Date:

Human Resources Branch Decision (EWS Manager, Assistant Branch Chief, Branch Chief)

☐ Approved ☐ Denied

☐ Modified as follows:

Personnel Officer Signature:	Date:

EEO Officer Decision (If Appealed)

☐ Modified as follows (See Attachment)
☐ Denial Upheld (See Attachment)
☐ Other _____

EEO Officer Signature:	Date:

If the request for Reasonable Accommodation is denied, a copy of the denial letter shall be sent to the Equal Employment Opportunity (EEO) Office.

Distribution: 1. Employee (Copy) 2. Human Resources Branch (Original) 3. Supervisor (Copy)