Request for Documentation of Functional Limitations

290 North D Street, Suite 600
San Bernardino, CA 92415
(909) 387-9859

CUSTOMER NAME:_____ **DATE:** _____

FROM: _____ **PHONE NUMBER:** _____

SUBJECT: (Request for information to assist in providing a reasonable accommodation for):

_____

The County of San Bernardino Department of Workforce Development is attempting to provide reasonable accommodation to the individual indicated above to assist in providing employment preparation services. The information requested below is confidential and will only be used to determine the specific equipment and/or services necessary to accommodate the identified limitations due to a verified disability.

Under the Americans with Disabilities Act (ADA), an individual with a disability is a person who:

- Has a physical or mental impairment that substantially limits one or more major life activities, such as walking, breathing, speaking, performing manual tasks, seeing, hearing, learning, caring for one's self, and working.
- Has a record of such an impairment.
- Is regarded as having such an impairment.

Please take the above definition into consideration when answering the following questions with respect to the customer's request for a reasonable accommodation.

Is the above-named customer an individual with a disability, as defined by the ADA? Yes ☐ No ☐

If yes, please complete the following questions.

1. Is the disability permanent? Yes ☐ No ☐ If no, what is the anticipated duration? _____

2. What major life activity or activities does the impairment limit?

☐ Walking	☐ Hearing	☐ Working
☐ Breathing	☐ Seeing	☐ Caring for one's self
☐ Speaking	☐ Learning	☐ Performing manual tasks

3. Does the limitation require accommodation? Yes ☐ No ☐ If yes, suggested accommodation: _____

Name of health care professional completing form (print name):

Agency:	Title:
Signature:	Date: