DISABILITY COMPLIANCE ASSESSMENT (D.C.A.)

The following form has been developed as part of our Disability Compliance Assessment (D.C.A.) service, which will provide you an initial consultation of your disability compliance situations. Complete this form and provide our office with available supporting documents. Feel free to call us at 877-984-7969 or email us at referral@R2WP.com or fax us at 877-984-9901. *FIELDS REQUIRED

DISCLAIMER: The information and materials available at this web site are for informational purposes only and not for the purpose of providing legal advice. You should contact your attorney to obtain advice with respect to any particular issue or problem. This brief outline of your disability compliance obligations is designed to provide accurate and authoritative information in a highly summarized manner in regard to the subject matter covered on this website. They provide the reader / end user with the understanding that the publisher of this information is not engaged in rendering legal advice / services. If legal assistance is required, the services of competent legal professionals should always be sought.

DATE: *	
JOB TITLE / POSITION HELD BY EMPLOYEE: *	
NATURE OF DISABILITY THAT AFFECTS THE EMPLOYEE'S ABILITY TO PERFORM JOB: ☐ WORK RELATED / WORKERS COMPENSATION ☐ NON INDUSTRIAL / NOT WORK RELATED ☐ UNKNOWN	
DATE OF INJURY / DATE OF KNOWLEDGE / ONSET OF DISABLING CONDITION:	
EMPLOYER: *	
NAME & TITLE OF CONTACT: *	
PHONE NUMBER: *	**EMAIL: ***

CURRENT WORK STATUS OF EMPLOYEE: ***(check all that apply)***

☐ **NOT WORKING**

☐ **WORKING IN REGULAR JOB**

☐ **WORKING IN MODIFIED JOB, REGULAR JOB WITH REASONABLE ACCOMMODATIONS IN PLACE**

☐ **WORKING IN ALTERNATE JOB, COMPLETELY DIFFERENT JOB, UNABLE TO SAFELY PERFORM REGULAR JOB WITH OR WITHOUT REASONABLE ACCOMMODATIONS**

☐ **WORKING FULL-TIME**

☐ **WORKING PART-TIME / MODIFIED WORK SCHEDULE**

☐ **TEMPORARILY TOTALLY DISABLED**

☐ **ON LEAVE OF ABSENCE: FMLA CFRA ADA FEHA GENERAL LEAVE OTHER: ______________________**

☐ **WORKING PART-TIME ____________ HOURS PER WEEK**

☐ **DATE LAST WORKED: ______________**

☐ **OTHER: ____**

WHAT EVENT TRIGGERED / INITIATED THE NEED FOR A REASONABLE ACCOMMODATION MEETING?

☐ **EMPLOYEE'S REQUEST FOR REASONABLE ACCOMMODATION**

☐ **EMPLOYER'S KNOWLEDGE OF WORK RESTRICTIONS**

☐ **NON-INDUSTRIAL RELATED / EMPLOYEE'S OWN MEDICAL CONDITION**

☐ **TEMPORARY WORK RESTRICTIONS**

☐ **PERMANENT WORK RESTRICTIONS RESULTING FROM AN INDUSTRIAL CLAIM**

☐ **NEW ADDITIONAL WORK RESTRICTIONS**

☐ **WORK RESTRICTIONS, HAVE UPDATED**

☐ **FOLLOW UP MEETING, ADDRESS ACCOMMODATIONS CURRENTLY IN PLACE**

☐ **RETURN TO REGULAR WORK / RELEASE TO FULL DUTY**

☐ **OTHER:** ____

HAVE YOU ENGAGED IN THE INTERACTIVE PROCESS WITH THE EMPLOYEE?

☐ **YES *(IF YES, PROVIDE NOTES)*** ☐ **NO**

THE FOLLOWING DOCUMENTS AND INFORMATION ARE NEEDED TO PROCESS YOUR REQUEST:

1. **COPY OF ALL AVAILABLE MEDICAL NOTES WITH WORK RESTRICTIONS.**
2. **PROVIDE WORK RESTRICTIONS FROM AGREED MEDICAL EXAMINERS, QUALIFIED MEDICAL EXAMINERS, PRIMARY TREATING PHYSICIANS, AS OUTLINED IN ALL MEDICAL NOTES.**
3. **CURRENT JOB DESCRIPTION OF JOB EMPLOYEE'S WILL BE RETURNING TO. EMPLOYEE'S REGULAR JOB**
4. **SUMMARY OF PRIOR INTERACTIVE MEETINGS / DISCUSSIONS WITH EMPLOYEE**
5. **SUMMARY OF CURRENT REASONABLE ACCOMMODATIONS IN PLACE**
6. **PERMANENT WORK RESTRICTIONS**
7. **TEMPORARY WORK RESTRICTIONS**

Upon completion of this form, please forward all supporting documents noted above via email to REFERRAL@R2WP.COM.
OR VIA FAX TO 877-984-9901