Certification from Health Care Provider
Support of a Request for an Emotional Support Animal
(Request for Reasonable Accommodation)

When an employee's disability or need for accommodation is not apparent or known to the employer, the employer may request a certification from a health care provider verifying that an accommodation is necessary. Please provide the following information on your patient:

Employee Name: _____

Disability Certification (Please do **not** provide diagnosis)
The California Department of Fair Employment and Housing defines an individual with a disability as someone who has a physical or mental disability that limits a major life activity. Does this employee have a disability? ☐ Yes ☐ No (If no, please sign, date, and return)

Work Restrictions and/or Functional Limitations
What are the employee's specific work restrictions and/or functional limitations?
Describe how these restrictions and limitations impair the employee's ability to perform the duties of the job:
Are these restrictions and limitations permanent or temporary? ☐ Permanent ☐ Temporary If temporary, how long will these restrictions be in place: _____

Emotional Support Animal as a Reasonable Accommodation
As this patient's health care provider, who is familiar with the patient's history and disability, are you recommending an Emotional Support Animal as a form of reasonable accommodation? ☐ Yes ☐ No How will this animal assist your patient in the performance of the essential functions of their position?

When responding to this request, please know that:

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you 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."

Signature Section		
Health Care Provider Name (print):	Address:	
Health Care Provider Signature:	Date:	License Number:

Please return completed form to your patient or fax to: University of California, Berkeley
Be Well at Work – Disability Management
Confidential Fax: (510) 642-6505