ALAMEDA COUNTY DESCRIPTION OF EMPLOYEE'S ESSENTIAL JOB FUNCTIONS

Supervisor/Manager: The development of this form is intended to describe the essential job functions of this position. Please provide a brief job description and list the essential job functions and related job demands/activities. The completed form will be reviewed by the treating /evaluating clinician to determine whether the employee is able to perform the essential job functions as described, and return to his/her position or alternate position. Please ensure that all information provided is current and accurate as this is an important document utilized to obtain information on how an employee's medical condition could/may impact his/her ability to perform the essential job functions with or without a reasonable accommodation.

Physician/Clinician: Your assistance is requested to identify what job functions the employee can or cannot do as currently performed. Following your review of the essential job functions and related job demands/activities and based on the employee's medical condition, please provide your responses as indicated (Sections 1-5). Your prompt reply is necessary so that the County can determine the return to work status of this employee.

For questions or clarifications, please contact _____, Department Disability Coordinator, at (___)_____ or the County of Alameda's Disability Programs Manager, Human Resource Services Department at (510) 208-9904.

EMPLOYEE NAME: (LAST) (FIRST)	**CLAIM # (if applicable):**
AGENCY/DEPARTMENT/EMPLOYER NAME:	**JOB ADDRESS:**

JOB TITLE:	**WORK SCHEDULE/HOURS WORKED PER DAY:**	**HOURS WORKED PER WEEK:**

ANALYSIS COMPLETED BY/TITLE: **DATE ANALYSIS COMPLETED:**

GENERAL JOB DESCRIPTION

ESSENTIAL JOB FUNCTIONS

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For Treating & Evaluating Physician/Clinician: (Complete sections 1 - 5)

Note: 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.

Section 1. Below is a listing of the physical activities and specific time requirements for this position. Please review and indicate the activity the employee "can or cannot perform" so that the County can determine the return to work status of this employee.

ACTIVITY **Supv/Mgr: Please indicate the specific amount of time each activity is performed. Include "N/A, Seldom (Up to 1 hour), Intermittent (Int)/Continuous (Cnt)," where applicable.**	RELATED ESSENTIAL FUNCTION(S) (TASK #)	OCCASIONAL 1 to 3 Hours p/day	FREQUENT 3-6 Hours p/day	CONSTANT 6-8 Hours p/day	CAN PERFORM (Yes)	CANNOT PERFORM (No)
Sitting						
Walking						
Running						
Standing						
Bending (neck)						
Bending (waist)						
Squatting						
Climbing						
Kneeling						
Crawling						
Twisting (neck)						
Twisting (waist)						
Hand Use: Dominant hand (Circle Right/Left)						
Repetitive Hand Use						
Simple Grasping (right)						
Simple Grasping (left)						
Power Grasping (right)						
Power Grasping (left)						
Keyboarding (right)						
Keyboarding (left)						
Mouse use (right)						
Mouse use (left)						
Pincher Grasping (right)						
Pincher Grasping (left)						

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ACTIVITY **Supv/Mgr: Please indicate the specific amount of time each activity is performed. Include "N/A, Seldom (Up to 1 hour), Intermittent (Int)/Continuous (Cnt)," where applicable.**	RELATED ESSENTIAL FUNCTION(S) (TASK #)	OCCASIONAL 1 to 3 Hours p/day	FREQUENT 3-6 Hours p/day	CONSTANT 6-8 Hours p/day	CAN PERFORM (Yes)	CANNOT PERFORM (No)
Torquing (circle right/left/both)						
Fine Manipulation (right)						
Fine Manipulation (left)						
Pushing-Pulling (right)						
Pushing-Pulling (left)						
Reaching At/Above Shoulder (right)						
Reaching At/Above Shoulder (left)						
Reaching Below Shoulder (right)						
Reaching Below Shoulder (left)						

Section 2. Physician/Clinician: Below is a listing of the lifting/carrying and specific time requirements for this position. Please review and indicate the activity the employee "can or cannot perform" so that the County can determine the return to work status of this employee.

	LIFTING/CARRYING						
	Never/ Seldom (Up to 1 hr)	**Occasionally 1 to 3 hrs p/day.**	**Frequently 3-6 hrs p/day**	**Constantly 6-8 hrs p/day**	**Distance Carried From/to**	**Can Perform (Yes)**	**Cannot Perform (No)**
0-10 lbs.							
11-25 lbs.			f				
26-50 lbs.							
51-75 lbs.							
76-100 lbs.							
100+ lbs.							

The heaviest item to be carried and the distance to be carried is:

KEY: Height object is lifted from/to - G: Ground W: Waist C: Chest S: Shoulder or above

Section 3. Physician/Clinician: Below is a listing of additional activities and specific time requirement for this position. Please review and indicate the activity the employee "can or cannot perform" so that the County can determine the return to work status of this employee.

Activity	**Required**	**(Brief description)**	**Can Perform (Yes)**	**Cannot Perform (No)**
FOR SAFETY POSITIONS: Requires involvement in altercations and/or physically restraining of suspects or clients				
Driving cars/ trucks/ forklift and other equipment				
Working around equipment or machinery				
Walking on uneven ground				
Exposure to excessive noise				
Exposure to extremes in temperature/humidity/w etness				
Exposure to dust, gas, fumes or chemicals				
Working at heights				
Operation of foot controls / repetitive movement				
Use of visual or auditory protective equipment				
Working w ith bio-hazards				

Employer comments (if applicable):

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Section 4. Below is a listing of social/psychological demands required for this position. Please review and indicate the demands the employee "can or cannot perform" so that the County can determine the return to work status of this employee.

SOCIAL/PSYCHOLOGICAL DEMANDS	Never/ Seldom Up to 1 hr	Occasional 1-3 hrs	Frequent 3-6 hrs	Constant 6-8 hrs	Can Perform Yes	Cannot Perform No
Ability to comprehend and follow instruction • Maintain attention and concentration for necessary periods of time • Understand written and oral instructions • Perform work requiring set limits, tolerances and/or standards						
Ability to perform simple tasks • Ask questions or request assistance • Perform activities of a routine nature • Remember locations and work procedures						
Ability to maintain a work pace appropriate to a given work load • Perform activities within a set work schedule, maintain regular attendance and be punctual • Complete a normal work day and/or work week and perform at a consistent pace						
Ability to perform complex and varied tasks • Synthesize, coordinate and analyze data • Perform jobs requiring precise attainment of set limits, tolerances or standards • Perform a variety of duties often changing from one task to another of a different nature without loss of efficiency or composure						
Ability to relate to other people beyond giving and receiving instructions • Interact appropriately with co-workers, peers, supervisors/managers • Perform work activities requiring negotiating, explaining, or persuading • Respond appropriately to evaluation or criticism						
Ability to influence • Convince or direct others • Understand the meaning of words and use them appropriately and effectively • Interact appropriately with people						
Ability to make generalizations, evaluations or decisions without immediate supervision • Recognize potential hazards, follow appropriate precautions • Understand and remember detailed instructions • Make independent decisions or judgments based on appropriate information						
Ability to accept and carry out responsibility for direction, control and planning • Set realistic goals and make plans independently of others • Negotiate with, instruct or supervise others • Respond appropriately to changes in work conditions						

Additional Employer Comments:
Employee's Review and Comments:
Review and Comments of Other Employees Performing this Job/Others Who Observed this Job:

EMPLOYER CONTACT NAME & TITLE:	**SIGNATURE & DATE:**
OTHERS WHO REVIEWED/PROVIDED INPUT (NAME & TITLE):	**SIGNATURE & DATE:**
HUMAN RESOURCES (REVIEWED BY) NAME & TITLE:	**SIGNATURE & DATE:**
EMPLOYEE'S NAME (REVIEWED BY) & CLASSIFICATION:	**SIGNATURE & DATE:**

Section 5: Treating/Evaluating Physician comments:

(If "NO" is checked under "Cannot Perform," please specify the employee's functional abilities/inabilities in relation to the activity/job demand and time requirement. Suggestions/recommendations (if known) for reasonable accommodation which will enable the employee to perform that activity for consideration is appreciated.) IMPORTANT: Please indicate below if work restrictions/limitations are permanent or temporary.

☐ **Please check here if restrictions are permanent.**

☐ **Please check here if restrictions are temporary. (Specify Dates) From: _____ through _____**

TREATING/EVALUATING CLINICIAN'S NAME:	**SIGNATURE & DATE:**