INTERACTIVE PROCESS (IAP), REASONABLE ACCOMMODATION, AND MEDICAL WORK RESTRICTION AGREEMENT (MWRA)

Stanislaus County conducts an Interactive Process (IAP) for employees with medical work restrictions preventing the employee from performing any one of the essential functions of his/her classification. The IAP is a collaborative effort between the employee and his/her supervisor and/or manager to determine if the employee can return to work in a safe manner, safely perform the essential job functions of the employee's current job assignment, and if necessary identify available reasonable accommodation.

The interactive process is an ongoing dialogue between the employee and manager/supervisor about possible options for reasonably accommodating the employee's disability. In general, the IAP may include:

- Job analysis including essential functions and assignments;
- Consulting with the employee regarding precise job related limitations (work restrictions);
- Consulting with the employee to identify potential accommodations and the effectiveness of each potential accommodation in enabling the employee to perform the essential functions of his/her job with or without accommodation(s); and
- Considering the employee's preference, and selecting and implementing the accommodation that is most appropriate for all parties involved.

Generally, a reasonable accommodation is one that effectively enables an employee to perform the essential functions of the job. Essential job functions are duties the employee is required to actually perform (the reason the position exists), and are fundamental and not marginal to the job.

Completion of a Medical Work Restriction Agreement (MWRA) is required to document each IAP interaction. Physical requirements of each classification are identified in the Job Task Analysis (JTA) documents available on the County Risk Management web page at http://www.stancounty.com/riskmgmt/risk-dm-home-main.shtm and position specific job specifications are available from Department HR staff.

Please follow each of these steps in conducting the IAP.

Step 1 – Confirm Medical Certification

Confirm the medical certification clearly identifies work restrictions and the effective dates. If it does, go to Step 2. If not, identify what is missing and work with Department HR representative on next steps to assist employee in obtaining a sufficient medical certification. For additional information, refer to "Guidelines for Medical Certification" available on the County Risk Management web page at http://www.stancounty.com/riskmgmt/docs/dm-forms/requirements-for-medical-certification.pdf.

Step 2 – Department Supervisor/Manager Review

The employee's supervisor and/or manager will evaluate the work restrictions and engage in the IAP with the employee to determine if the employee can safely perform the essential job functions of the employee's current job assignment, and to consider possible reasonable accommodations as appropriate. Document whether the employee can perform their essential job functions in a safe manner, whether a reasonable accommodation is needed, and clearly identify the proposed reasonable accommodation(s) on the MWRA form. If required by your Department, forward the completed proposed MWRA form to your designated Human Resources (HR) representative (Step 3) for review and/or to assist with identifying a reasonable accommodation(s) as appropriate.

Step 3 – Human Resources Assistance

Designated Department HR or Management/Supervisory staff who have been trained in Disability Management, or CEO HR Management Consultant will review information documented in Step 2, and if necessary, assist the supervisor and/or manager with identifying a reasonable accommodation(s). If a reasonable accommodation is identified and has been reviewed by the Designated Representative as described above, have all parties sign the MWRA form. If a reasonable accommodation is not identified, complete as much of the form as possible, attach documentation for each step of the process, and provide all of the following documents to CEO-HR: copies of medical notes considered; summary of meetings conducted; employee or department suggestions and alternatives considered throughout the process; and any written documentation with the employee regarding the medical restrictions (emails, letters, etc.).

Step 4 –Signatures and Distribution

Once the MWRA has been reviewed and signed by the Designated Representative in Step 3, obtain remaining signatures (Supervisor or Manager and Employee). Give a copy of the completed MWRA form to the Employee. Email a copy of the finalized MWRA form and medical certification to Risk Management to be placed in the employee's medical file. If employee is working a reduced work schedule, contact CEO-Risk Management at 525-5710 to avoid delay in benefit payments.

MEDICAL WORK RESTRICTION AGREEMENT

☐ **On the Job Injury/Illness – Workers' Compensation** ☐ **Off the Job Injury/Illness**

Date of injury _____ Claim # _____

Employee Name: _____ Phone # _____

Supervisor Name:_____ Phone # _____

Department Name: _____ Employee ID # _____

Job Classification:_____

Medical Provider's Name: _____

Medical work restrictions (Attach Medical Certification):

☐ Temporary Work Restrictions Effective: _____ to _____

☐ Permanent Work Restrictions Effective: _____

REASONABLE ACCOMMODATION SECTION

Can the employee safely perform the essential job functions without a reasonable accommodation?

☐ Yes ☐ No. If no, please complete the appropriate sections below.

The Department and employee agree to the following accommodations:

Reasonable accommodation effective dates (review every 90-days): _____ to _____

Next IAP meeting (if needed): Date:_____ Time: _____

☐ **A Reasonable Accommodation was NOT Identified after completing Step 3 (attach documentation)**

A CEO-HR Consultant must be contacted **prior** to sending an employee home or determining that the department is not able to reasonably accommodate and the CEO HR Consultant must sign this form before proceeding.

EMPLOYEE ACKNOWLEDGEMENT OF IAP

I, the undersigned, acknowledge that I have medical work restrictions as outlined on this form and I agree to comply with these work restrictions. I understand that I am required to immediately notify my supervisor, manager, or other management staff as necessary, if I am requested to perform duties that exceed these work restrictions. ***I further agree to keep my supervisor informed in the event my doctor changes these restrictions and if I transfer to another supervisor, I understand and agree that I will notify my new supervisor of my work restrictions. I acknowledge that time away from work to attend doctor appointments, medical treatment appointments and physical therapy appointments is not compensable through Workers' Compensation; however, I may request to use sick leave or other applicable leave accruals.***

Based on these medical work restrictions, I have engaged in the IAP with my supervisor and/or manager to determine if I can safely perform my essential job functions with or without a reasonable accommodation as documented on this MWRA form. I understand and agree with the documented reasonable accommodations contained on this form. If the agreed upon accommodations are not working as expected I will immediately notify my supervisor. I understand that this accommodation will be provided as long as it is effective at allowing me to perform the essential functions of the job within the documented job-related limitation or until the County is no longer able to provide this accommodation based on an assessment of business or operational necessity. I also understand that the MWRA form does not represent a permanent change to my duties or responsibilities.

Signature of Employee	**Date**

MANAGER/SUPERVISOR ACKNOWLEDGEMENT OF IAP

I have met with the employee and engaged in the IAP to determine if the employee can perform his or her essential job functions in a safe manner and to identify a reasonable accommodation, as appropriate and as identified above. This accommodation will be provided for the term specified, or as long as it is effective at allowing the employee to safely and effectively perform the essential functions of his/her position, or until the Department is no longer able to provide this accommodation based on an assessment of business or operational necessity. If one of these situations occurs, or as otherwise needed, I understand that I must reengage in the IAP with this employee. I understand it is my responsibility, to the best of my ability, to ensure the employee does not perform functions that exceed these work restrictions. I further understand, in the event that the accommodation does not appear to be effective at allowing the employee to safely and effectively perform the essential job functions, I will immediately address concerns using open and supportive communication through the IAP.

Signature of Manager/Supervisor	**Date**

HUMAN RESOURCES REVIEW OF IAP

I have read and reviewed the information contained on this MWRA form and the attached medical certification. Based on the information provided, the identified reasonable accommodation(s) appear to be appropriate.

Signature of Human Resources Manager/Designee	**Date**