Sonoma County Office of Education

INTERACTIVE REVIEW related to COVID-19

Sonoma County Office of Education (SCOE) has been notified the listed employee has a medical and/or physical condition related to COVID-19. Be advised this information should be kept confidential..

Employee Name:	Employee Phone Number:
Employee Job Title:	Employee Worksite Location:
Supervisor:	Supervisor Phone Number:
Type of notification: *** (WSR, medical note, employee notified orally)	Date of notification:
Has the employee been placed off of work by medical provider?	If yes then list beginning and ending dates:

Indicate the employee's COVID condition/situation: (*Check all that apply)*

☐Chronic health condition which places employee in the high exposure risk category.

☐Has an actual (or record of) disability (i.e. Immune compromising disease, respiratory disease, anxiety disorder, obsessive-compulsive disorder, PTSD, etc*).*

☐Experiencing COVID related symptoms: Date of appointment with medical provider:

☐Due to certified exposure, required to self-isolate: Begin date: End date:

☐Awaiting or needing COVID testing: Date of test:

☐Employee unable to RTW due to closure or dependent's school or place of care.

☐ Other_____

Interactive meeting with employee: Date: Time:

Attendees:

Meeting Conducted ☐ in person ☐ over the phone ☐ zoom

INTERACTIVE PROCESS	
Indicate a completed step by placing a check mark in right column:	√
Review the temporary or permanent work restrictions with the employee, as listed on the Work Status Report and/or Return to Work Agreement. Does the employee agree with the work restrictions? ☐ Yes ☐ No	☐
Review the employee's job description and identify the essential and non-essential functions of the job with the employee.	☐
Engage in a collaborative, interactive conversation with the employee and discuss various "reasonable" accommodations, if any.	☐
Ask the employee for his/her input or feedback on what duties they think they can perform within their restrictions.	☐
Complete the Return to Work Agreement with the employee noting whether or not you can accommodate the restrictions – provide employee with a copy and original to HR contact.	☐
AFTER INTERACTIVE MEETING:	
o Complete Return to Work Agreement (RTW) on page 2 summarizing the following: o Employee's restrictions o Employees input and/or feedback o Agreed upon accommodations listing start and end date o Job modifications A confirmation letter will be sent to the employee by the HR contact.	☐
The Interactive Process is continuous, so be sure to check in on the employee regularly to review the ongoing effectiveness of the accommodation and don't forget to document. Additional interactive meetings should be held if the work restrictions change significantly.	
All steps of the Interactive Process must be timely, in good faith and documented.	

Sonoma County Office of Education

NON-Industrial Return to Work Agreement

Employee:	Date of notice:
Job Title:	District: Sonoma County Office of Education

Your medical physician has provided written notification of the following temporary work restriction(s) for you:

Effective Dates:

(Employer Complete) Temporary/Alternative Work Arrangement Agreement

Temp Arrangement Available ☐ Yes ☐ No Start Date:

(Employer Complete)	*(Employer Complete)*
Prior to Injury was employee Full-Time or Part-Time: Full-Time/Hours per week: _____ Part-Time/Hours per week: _____	Will employee be working normally scheduled work hours? ☐ Yes ☐ No *if no, please note how many hours employee will be working per week: _____

Be advised of the following

- Temporary/alternative work assignments/modifications are designed for temporary placement only.
- All regular personnel policies and procedures with respect to attendance and performance will apply as usual while you are participating in this alternative or temporary work period.
- If you are unable to perform any of your assigned temporary hours and/or job tasks, immediately advise your supervisor and/or Sonoma County Office of Education Human Resource Services department.
- You will need a Work Status Report/Disability Slip from your treating physician to cover any lost days.
- After each medical appointment it is your responsibility to provide SCOE with an updated copy of the Work Status Slip listing your new temporary restrictions.
- In order to prevent further injury or aggravation to my condition, I agree that I will work within my work restrictions. I furthermore acknowledge that this agreement does NOT represent a permanent change of duties or responsibilities.

(Employee Choose One)

☐ Accept Assignment ☐ Decline Assignment ☐ No Assignment is Available ☐ Restrictions Do Not Apply to Job

Employee Signature:	Date:
Supervisor Signature:	Date:

Temporary accommodation(s) will not exceed work restrictions indicated by your physician. You will receive regular wages provided that your accommodation remains at your normal number of scheduled hours. Refusal to accept a temporary work accommodation may result in denial of education code and/or temporary total disability benefits.