The sample forms provided as part of this presentation are intended merely for informational purposes. No representation is made as to the enforceability of these forms in any jurisdiction, and the materials should not be relied upon or construed as legal advice, or as a substitute for obtaining legal advice from an attorney licensed in the applicable jurisdiction(s).

Reasonable Accommodation/Interactive Process Letter & Questionnaire
Response to Request for Accommodation

[Name of Company Contact]
[Employer Name]
[Address]
[Telephone Number]
[Email]

[Date]

<u>Via Overnight Delivery</u>

[Employee Name]
[Street Address]
[City, State Zip]

RE: ***Request for Accommodation***

Dear [Employee Name]:

{Sample introduction*: Since* [Date]*, you have been absent from work at* [Location] *due to* [describe condition]*. In a letter dated* [Date]*, you informed* [Employer] *that you needed to* [describe requested accommodation] *because of some undisclosed condition that you have referred to as a "disability." You also submitted a letter from* [Doctor's Name]*, which stated that the* [accommodation] *is necessary to allow you to perform your job duties.}*

While you may be entitled to some reasonable accommodation under the Americans with Disabilities Act ("ADA") and/or applicable state law, we must first engage in a dialogue with you to determine the nature of your condition, the nature and extent of any physical or mental limitations that you may have as a result of your condition, and whether you may be entitled to the accommodation that you have requested or whether there may be some other reasonable accommodation that would allow you to perform the essential functions of your job as a [Job Title] in a satisfactory manner. This is referred to as the "interactive process."

Enclosed is a form that must be completed by a qualified behavioral healthcare provider relating to your current condition. Please take this letter and the enclosed form to your healthcare provider and ask him/her to provide all of the requested information. The form must be signed by your healthcare provider and returned to us by [Date]. Failure to provide the requested information in a timely manner may result in the termination of the interactive process. Thank you for your anticipated cooperation in securing your doctor's response to this request. Please contact me if you have any questions or concerns.

Sincerely,

Enclosure

Ogletree Deakins

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[COMPANY NAME]

INTERACTIVE PROCESS QUESTIONNAIRE

[Company Name] is engaged in the interactive process with [Employee Name] ("the Employee") to determine whether the Employee may be entitled to a reasonable accommodation. As part of that process, we require the information requested herein.

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from obtaining genetic information as to any employee or family member 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 members receiving assistive reproductive services.

1. What is your diagnosis of Employee's condition?

   Response: ____

   ____

   ____

   ____

   ____

2. What is your opinion as to the cause of Employee's condition?

   Response: ____

   ____

   ____

   ____

   ____

3. Provide a detailed description of the nature and severity of Employee's symptoms.

   Response: ____

   ____

   ____

   ____

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4. Please describe the proposed course of treatment.

Response: ____

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5. What is your prognosis as to the duration of Employee's condition?

Response: ____

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6. Please describe in detail the limitations on the Employee's regular life activities as a result of the Employee's condition and/or the treatment of the condition (e.g., ability to care for himself/herself, ability to stand, sit, walk, see, eat, sleep, lift, climb stairs, read, concentrate, think, etc.) and the expected duration of such limitations. The description of the Employee's limitations must be as objective and specific as possible. Regarding the duration of the Employee's limitations, please be as specific as possible (e.g., ten days; three weeks; two months, etc.). If the duration of the Employee's limitations is indefinite or permanent, so indicate.

Response: ____

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7. State whether the Employee's condition precludes him/her from performing any of the essential physical or cognitive functions of his/her job. To assist you in this regard, a job description that sets forth the essential physical and cognitive functions of the Employee's job is attached.

   ______ Yes **______ No**

8. If the Employee's condition does preclude him/her from performing any of the essential functions of his/her job, please identify the specific job functions that the Employee is unable to perform.

   Response: ____
   ____
   ____
   ____
   ____
   ____

9. If you believe that there are any reasonable accommodations (i.e., modifications or changes to the work environment or to how the work is typically done) that would permit the Employee to perform the essential functions of his/her job listed in the response to Item No. 8 **at this time**, please describe the accommodation(s).

   Response: ____
   ____
   ____
   ____
   ____
   ____

10. If the Employee is not currently able to perform all of the essential functions of his/her job, with or without accommodation, please provide your medical opinion as to the anticipated return to work date for the Employee (i.e., the date when the Employee would be able to perform all of the essential physical and cognitive functions of his/her job with or without reasonable accommodation). If you are unable to identify a return to work date at this time (i.e., the Employee will be unable to perform all of the essential job functions with or without reasonable accommodation for an indefinite period of time or permanently), so indicate. Note: A statement that the Employee will not be able to return to work until "at least" a given date is not helpful in the context of this process. Such assessment will be deemed the equivalent of a statement that the Employee will be unable to return to work for an indefinite period.

Response: ____

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11. If you believe that there are any reasonable accommodations (i.e., modifications or changes to the work environment or to how the work is typically done) that would permit the Employee to perform the essential functions of his/her job listed in the response to Item No. 8 **on his/her return to work date**, please describe the accommodation(s).

Response: ____

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12. Is there a significant risk of substantial harm to the health or safety of the Employee or other individuals if the Employee is allowed to perform the duties of his/her position?

______ **Yes** ______ **No**

13. If your response to Item No. 12 is "YES," please describe the risk of harm.

Response: ____

____

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____

____

14. Are there any accommodations that would reduce or eliminate any direct threat that you have identified in your response to Item 13 above?

Response: ____

____

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____

____

____
Signature of Healthcare Provider

____
Print Name

Date:_______________________________

Note: If you would like to observe someone performing the duties of the Employee's position before you respond to this questionnaire, please contact [Name of Company Contact] to arrange a time for such observation.

[Name of Company Contact]
[Address]
[Telephone Number]
[Email]

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If you have any questions about this form, please contact Ogletree Deakins shareholder Richard C. Mariani at (973) 656-1600 or richard.mariani@ogletreedeakins.com.

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