Reasonable Accommodation Request

Dear Employee,

The purpose of this letter is to inform you that Athletico has been made aware of a possible medical condition which *may* entitle you to a reasonable accommodation under the Americans with Disabilities Act (ADA). At this time we are engaging in the interactive process of obtaining your request for an accommodation to assist you in performing the essential functions of your job. Please review and complete the enclosed reasonable accommodation request forms. Please also provide the enclosed Medical Certification for Reasonable Accommodation to your healthcare provider for completion. If a copy of your job description is needed from your healthcare provider, please contact Leaves@Athletico.com to request a copy.

What You Need to Know
The ADA requires employers to provide qualified employees with disabilities (as defined by the act) with reasonable accommodations in order to perform the essential functions of their jobs. If you believe you have a disability under the ADA, can provide medical documentation of this disability, and demonstrate that an accommodation would allow you to continue your regular work schedule and perform your essential job functions, within a reasonable amount of time, Athletico will consider your request as a potential reasonable accommodation under the ADA. For more resources on reasonable accommodations, please visit https://www.athleticobenefits.com/loa-accom.

What You Need to Do
If you wish to apply for an accommodation of a disability, you will need to have your healthcare provider complete and return the attached Medical Certification for Reasonable Accommodation within the next fifteen (15) calendar days from the receipt of this letter.

If you will not be able to return a completed Medical Certification for Reasonable Accommodation within the required time frame, you must let us know as soon as possible so that we may consider granting you an extension of that time. It is your responsibility to provide us with a completed and sufficient Medical Certification for Reasonable Accommodation in a timely manner. If we do not receive the requested documentation within a timely manner and no extension has been approved, your request may be denied or there may be a delay in the commencement of your accommodations until the requested documentation is received. The Medical Certification for Reasonable Accommodation is necessary for Athletico to make an individualized analysis as to whether you are entitled to an accommodation under the ADA.

If you have any questions, please contact the Athletico Leave Department at the contact information listed below.

Sincerely,

Athletico Leave Department
Athletico Physical Therapy
2122 York Road, Suite 300, Oak Brook, IL 60523
P: 630.575.6280 opt 2 | F: 630.928.3429
Leaves@athletico.com

ATHLETICO
PHYSICAL THERAPY

MEDICAL CERTIFICATION FOR REASONABLE ACCOMMODATION REQUEST

Patient (Employee) Name: Employee ID#:

TO BE COMPLETED BY HEALTHCARE PROVIDER

Your patient has requested a reasonable accommodation. Athletico requests that the treating physician(s) of the above named employee provide information to enable Athletico to assess whether there is a reasonable accommodation that it can provide to permit the employee to perform the essential functions of their position. The employee has been advised that this form must be fully completed by you and returned no later than 15 calendar days from the date of the request. Failure to return the form by that day may jeopardize the employee's continued employment.

Questions to help determine whether an employee has a disability

Under the ADA, an employee has a disability if he or she has a physical or mental impairment that substantially limits one or more major life activities or has a record of such impairment. The following questions may help determine whether your patient has a disability.

Does your patient have a physical or mental impairment? ☐ YES -or- ☐ NO
(*This may include a **temporary** impairment*)

Is the medical condition pregnancy-related? ☐ YES -or- ☐ NO | If so, expected delivery date: _____ (MM/DD/YYYY)

Substantial limitations. Does the impairment substantially limit a major life activity? ☐ YES -or- ☐ NO
(A major life activity is substantially limited when compared to most people in the general population; and/or when it is permanent or long-term.)

Questions to help determine whether an accommodation is needed.

An employee is entitled to an ADA accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested (or a different) accommodation (including those that may mitigate a requested absence) is needed because of the disability. Discuss with your patient about the essential job functions typically performed to answer the following questions.

Are job functions impeded? Do the limitations to major life activities indicated above impede or prevent your patient from performing his/her job functions? ☐ YES -or- ☐ NO

If yes, which job functions are impeded by the limitation? Which job functions is the employee unable to perform, or which benefits of employment are inaccessible without accommodation? In what way(s) do the employee's limitation(s) impeded his/her ability to perform typical job function(s) or access benefits of employment?

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Please provide any additional information that you believe would assist Athletico in determining, in consultation with the employee, whether an accommodation can be provided to permit him/her to perform his/her job at Athletico. We stress that you should **not** provide information that should not be disclosed under GINA.

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_____

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_____

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ATHLETICO
PHYSICAL THERAPY

MEDICAL CERTIFICATION FOR REASONABLE ACCOMMODATION REQUEST

TO BE COMPLETED BY HEALTHCARE PROVIDER

Questions Related to Leave of Absence

Does the patient require time away from work? If yes, please complete the questions below. ☐ YES -or- ☐ NO

Start date of leave:_____-_____-_____. (MM/DD/YYYY)

Is there a definitive (confirmed) date on which the employee can return to work? ☐ YES -or- ☐ NO

If yes, what is the definitive return to work date:_____-_____-_____. (MM/DD/YYYY)

If no, what is the speculative (estimated) return to work date?: _____-_____-_____ (mm/dd/yyyy)

Next scheduled appointment / evaluation:_____-_____-_____. (MM/DD/YYYY)

Do you anticipate the treatment(s) provided by your office will improve the employee's condition, and subsequently, return the employee to work and perform all essential functions of their position? ☐ YES -or- ☐ NO

Do you have any suggestions, other than time away from work, regarding possible accommodations to enable performance of job functions? If yes, please specify below. ☐ YES -or- ☐ NO

_____

_____

_____

Intermittent Leave: Is the patient able to work but needs occasional time off as an accommodation? ☐ YES -or- ☐ NO

Treatments/Appointments – Will the patient need to miss work for treatments or appointments? ☐ YES -or- ☐ NO

Frequency: May occur up to _____ per _____ (week, month, OR year)

Duration: Each treatment/appointment may last up to: _____ (Hours -or- Days)*

**Please consider travel time when calculating treatment/appointment duration.*

Episodes/Flare-ups – Will the employee's substantial limitations in an active state affect his or her ability to perform job functions? ☐ YES -or- ☐ NO

Frequency: May occur up to _____ per _____ (week, month, OR year)

Duration: Each episode may last up to: _____ (Hours -or- Days)

HEALTHCARE PROVIDER INFORMATION & SIGNATURE (REQUIRED)

Name & Credentials: **Fax Number:**

Provider's Signature: **Date:**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the law, we ask that your do 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 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. For purposes of California: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we ask that your do NOT provide any genetic information when responding to this request for medical information. "Genetic Information", as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

Please return the completed medical certification to the patient or mail, fax, or email a copy to the address shown below:

Athletico Leave Department
2122 York Road, Suite 300, Oak Brook, IL 60523
Phone: 630.575.6280 opt 2 | Fax: 630.928.3429
Leaves@athletico.com

EMPLOYEE APPLICATION FOR REASONABLE ACCOMMODATION

TO BE COMPLETED BY THE EMPLOYEE

The purpose of this form is to enable you to request a reasonable accommodation under the federal Americans with Disabilities Act (ADA) and applicable state law. As a part of the evaluation of your request for accommodation, we need information regarding the work limitations associated with your disability or medical condition, and your requested accommodation(s). **Please complete, sign and return this form to the Athletico Leave Department.** Once submitted, you may be contacted for additional information. As a part of the accommodation process, you will be provided with a Medical Certification Form for completion by your health care provider. The information you and your health care provider provide to us will be treated as confidential and will be maintained in a confidential file separate from your personnel file. The information will only be used to determine if a reasonable accommodation is available to you. Access to the information will be limited only to those with a need-to-know. Your manager will be notified that you have requested an accommodation, but the nature of the disability or medical condition will not be disclosed, unless directed by you to do so.

General Information

Name: Employee ID#:

Phone #: Personal Email:

Questions to clarify accommodation requested and document the reason for accommodation request.

Is your disability or medical condition requiring accommodation: ☐ Permanent -or- ☐ Temporary -or- ☐ Undetermined

If temporary, how long is it expected to last? _____

What specific accommodation are you requesting? If you are not sure what accommodation is needed, please provide any suggestions about what options we can explore.

_____

_____

_____

_____

_____

Is your accommodation request time sensitive? If yes, please explain. ☐ YES -or- ☐ NO

_____

_____

What, if any, job function(s) are you having difficulty performing? Identify the specific accommodations needed in order for you to perform the essential functions of the job (e.g., adjustments to work environment or job duties, physical restrictions, new or modified equipment, new resources, etc.) and describe how the accommodations would allow you to perform the essential functions of the job:

_____

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Please note: If your request if for the use of a support animal, you will be required to provide records of the animal's training, certifications, and immunizations. Please contact **Leaves@Athletico.com** with any questions.

Please Continue to Page Two

TO BE COMPELTED BY THE EMPLOYEE

Have you had any accommodations in the past for this same limitation? □ YES -or- □ NO

If yes, what were they and how effective were they?

_____

_____

Please provide any additional information that might be useful in processing your accommodation request:

_____

_____

_____

_____

_____

Questions Related to Leave of Absence

Do you require time away from work? If yes, please complete the questions below. □ YES -or- □ NO

Start date of leave:_____-_____-_____. (MM/DD/YYYY)

Is there a definitive (confirmed) date on which you can return to work? □ YES -or- □ NO

If yes, what is the definitive return to work date:_____-_____-_____. (MM/DD/YYYY)

If no, what is the speculative (estimated) return to work date?: _____-_____-_____ (mm/dd/yyyy)

Next scheduled appointment / evaluation:_____-_____-_____. (MM/DD/YYYY)

Employee Acknowledgement

By submitting this request, I certify that I have a disability or medical condition that requires reasonable accommodation, which I believe will be met by the requested accommodation(s).

I understand that this request is not a guarantee of an accommodation, and that Athletico may approve or deny the request, or offer an alternate reasonable accommodation.

I understand should my disability status change and the accommodation requested need to be re-evaluated or extended, I must notify the Athletico Leave Department as soon as possible. I understand updated documentation from my healthcare provider will be required.

I understand I must submit the requested documentation within 15 calendar days, and that I must notify the Athletico Leave Department of any delay in obtaining the requested documentation.

_____

Employee Name (Print)

_____ _____

Signature Date

Please return the completed request form and medical certification to the Athletico Leave Department at the address shown below:

Athletico Leave Department
Phone: 630.575.6280 opt 2 | Fax: 630.928.3429
Leaves@athletico.com