envoy

ACCOMMODATION REQUEST – HEALTH CARE PROVIDER

Instructions: Employee should complete Sections 1 and 6. In addition, please ask your health care provider to complete Sections 2- 5.

SECTION 1 – EMPLOYEE INFORMATION

Name		Employee Number		Home Telephone	
Address		City		State	Zip
Department		City		Supervisor	Work Telephone
Current Position					

Employee Certification and Medical Release:

I hereby authorize a health care provider representing Envoy Air to contact the undersigned health care provider for purposes of making disability related inquiries such as whether I have a disability, the need for any reasonable accommodation, and the nature of any such accommodation.

_____ _____

Employee's Signature Date

SECTION 2 – DETAILS OF EMPLOYEE'S CONDITION

The employee identified above has requested a job accommodation from his/her employer. In order for the Company to properly evaluate the request, the following information is requested to help determine whether the employee has a disability.

Does the employee have a physical or mental impairment? ☐ Yes ☐ No

If yes, what is the impairment?_____

What is the duration of the employee's impairment? _____

Does the impairment affect any of the following:
(Check any that apply)

☐ Caring for Self	☐ Walking	☐ Hearing	☐ Lifting
☐ Interacting with Others	☐ Standing	☐ Seeing	☐ Sleeping
☐ Performing Manual Tasks	☐ Reaching	☐ Speaking	☐ Concentrating
☐ Breathing	☐ Thinking	☐ Learning	☐ Operation of Bodily Function
☐ Working	☐ Sitting	☐ Eating	☐ Reacting
☐ Bending	☐ Reading		
☐ Other_____			
☐ None of the above			

Does the impairment substantially limit the ability of the employee to perform any of the activities you identified as compared to most people in the general population? ☐ Yes ☐ No

envoy

ACCOMMODATION REQUEST – HEALTH CARE PROVIDER

SECTION 3 – QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

Please see the attached job description to complete this Section.

What limitation(s), if any, interfere with the job performance or the employee's ability to access an employment benefit?

_____

_____

_____

How do the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access an employment benefit?

_____

_____

_____

SECTION 4 – QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

Do you have any suggestions regarding possible accommodations to enable the employee to successfully perform his/her job or access an employment benefit? If so, what are they?

_____

_____

_____

Would performing any of the job functions result in a direct safety or health threat to this employee or other people? Is there any other accommodation you would recommend which would eliminate this threat?

_____

_____

_____

SECTION 5 –TREATING HEALTHCARE PROVIDER INFORMATION

Health Care Provider's Name (Print)_____

Today's Date_____ Type of Practice_____ State (location) of Practice_____

Other Phone Number_____ Office Fax_____

Treating Health Care Provider's Signature_____

SECTION 6–EMPLOYEE'S CERTIFICATION

I CERTIFY THAT ALL STATEMENTS AND ANSWERS PROVIDED BY ME OR MY HEALTH CARE PROVIDER ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION OF MY MEDICAL HISTORY OR REQUEST MAY BE CAUSE FOR DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION.

Employee's Signature _____ Date_____

Please give completed form to your Human Resources Representative or send completed form to:

Envoy Air
4301 Regent Blvd. MD 240 • Attention: Compliance • Irving, TX 75063
Fax (833) 233-2912 • email: Envoy.HR.Compliance@aa.com