**ADA Accommodation Undue Hardship or not Qualified Individual with a Disability (QID) (FD1111)**

Send Certified and Regular Mail

Certification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

NAME

ADDRESS

Dear NAME:

This letter will serve to clarify your current employment and leave status with COMPANY. You are currently on a conditional leave as an accommodation under the Americans with Disabilities Act (ADA).

This letter shall serve to confirm COMPANY has been informally providing an accommodation since DATE, as follows:

* LIST OUT ACCOMMODATIONS

COMPANY received your ADA Essential Function Job Analysis - Health Care Provider Form dated DATE that states:

* LIST VERBATIM WHAT THE MED CERT SAYS – IF IT SAYS CLEAR FOR ALL DUTIES, PUT THAT.

Our records indicate the following: Date

* ADA Good Faith Interactive Meeting(s) \_\_\_\_\_\_
* ADA Good Faith Interactive Meeting(s) \_\_\_\_\_\_
* ADA Good Faith Interactive Meeting(s) \_\_\_\_\_\_

As per our discussion on DATE, it was confirmed your current medical condition prevents you from either performing the functions of your job position or returning to work at all in the near future, with or without accommodation.

**It is our understanding you are unable to return to work with or without accommodations**, therefore your conditional accommodation under the ADA has ended, as it has been determined you are unable to perform the essential functions of the job, with or without and accommodation **OR** it has been determined it is an undue hardship to provide an accommodation.

On DATE, an interactive good faith meeting was conducted with your input, regarding the ability of COMPANY to accommodate your current restrictions as indicated on the medical certificate dated DATE by NAME OF HEALTH CARE PROVIDER, with or without an Undue Hardship. Our records indicate neither COMPANY, our Human Resource Consultant [ONLY IF APPLICABLE], your health care provider, nor yourself, were able to identify any reasonable accommodation, which would allow you to perform the essential functions of your POSITION TITLE.

If you are currently enrolled in healthcare benefits, and you are in an unpaid leave of absence, your benefits will end the first day of the month following the month in which the unpaid leave begins. [VERIFY POLICY] COBRA information will follow under a separate cover at that time. [DELETE IF NOT APPLICABLE]

It is our desire to provide you the full opportunities available to you under state and federal law, as well as our own policies.

If you have any questions about the ADA or other benefits, please contact:

Name: NAME, TITLE

Phone: PHONE NUMBER

Enclosures

1. Disability Insurance Information [SPECIFIC TO YOUR STATE AND/OR COMPANY]