**FEHA/ADA Accommodation Conditional Designation - Good Faith Meeting Third and Final Notice (FDC1106)**

Send Certified and Regular Mail

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

DATE

EMPLOYEE NAME

ADDRESS

Dear EMPLOYEE NAME:

Per our prior correspondence on DATE and DATE, we provided you with a temporary accommodation pending clarification from your health care provider of your need for an accommodation. Our records indicate you have not provided the requested documentation nor have you participated in the scheduled Good Faith Interactive Meeting. [INCLUDE BOTH CLAUSES IF THEY APPLY AND/OR CLARIFY WHICH MEETINGS THEY ATTENDED

This letter will serve to clarify your conditional accommodation will end DATE [THREE WORKING DAYS FROM THE DATE OF THIS LETTER] if you do not provide documentation from your health care provider on or before DATE [SAME DATE OR PREVIOUS].

We have scheduled a Good Faith Interactive meeting with you, NAME, TITLE, COMPANY and NAME ALL PARTIES ATTENDING, to discuss the FEHA/ADA accommodation issues on:

Date and Time –DATE & TIME [3 WORK DAYS FROM THE DATE OF THIS LETTER]

Location –ADDRESS

Contact Name / Phone –NAME, NUMBER

It is our desire to provide you the full opportunities available to you under the Americans with Disabilities Act, as well as our own policies.

However, if you do not respond to this letter within the next three business days, we will accept this as confirmation you are not interested in participating in an interactive good faith process and are not requesting an accommodation at this time.

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

Name: NAME, TITLE

Phone: PHONE NUMBER

Enclosure:

1. CA State Disability Insurance Information
2. FEHA/ADA - Essential Function Job Analysis, Health Care Provider Evaluation Form
3. Job Description [INCLUDE EXACT NAME OF POSITION]
4. Authorization for Release of Medical Information [DELETE IF ALREADY RECEIVED]