**FEHA/ADA Accommodation Conditional Designation - Good Faith Meeting Second Notice (FDC1105)**

Send Certified and Regular Mail

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

DATE

EMPLOYEE NAME

ADDRESS

Dear EMPLOYEE NAME:

In our letter to you dated DATE, we informed you that your temporary accommodation began on DATE. At that time we requested you have your health care provider complete an FEHA/ADA Essential Function Job Analysis Health Care Provider Evaluation Form (FEHA/ADA Medical Certificate). Our records indicate you have not provided the requested documentation nor did you participate in the scheduled Good Faith Interactive Meeting. [INCLUDE BOTH CLAUSES IF THEY APPLY]

COMPANY requires additional documentation be provided to this office in order to facilitate an ongoing discussion regarding your potential need for an FEHA/ADA accommodation. We have again enclosed an FEHA/ADA Medical Certificate and a current job description for the position of JOB TITLE. Please discuss the job description with your health care provider and have him/her refer to it when completing the FEHA/ADA Medical Certificate.

Failure to provide the required documentation by the date indicated below may result in denial of an accommodation under the FEHA/ADA, and may subject you to disciplinary action, up to and including termination.

We have rescheduled the Good Faith Interactive meeting with you, NAME, TITLE, COMPANY and NAME ALL PARTIES ATTENDING, to discuss potential FEHA/ADA accommodations to:

Date and Time –DATE & TIME [5 WORKING DAYS FROM DATE OF LETTER]

Location –ADDRESS

Contact Name / Phone –NAME, NUMBER

Upon receipt of this letter, it is your responsibility to confirm your appointment time. You may return the FEHA/ADA Medical Certificate on or before the meeting scheduled for GOOD FAITH MEETING DATE.

**If your accommodation includes leave or a reduced work schedule, please note the following:**

* Per COMPANY policy, you must use/may use PTO, sick and/or vacation before eligibility for an unpaid leave of absence [VERIFY COMPANY POLICY].
* If you are eligible for LIST PROGRAM: COMPANY STD OR LTD OR OTHER COMPANY DISABILITY BENEFIT, AND OR STATE DISABILITY PROGRAM NAME your disability benefits, PTO, sick and/or vacation leave pay [VERIFY COMPANY POLICY] may/will be coordinated so that your payments do not exceed your normal rate of pay.
* At this time:

☐ You have NUMBER OF HOURS available of accrued unused PTO/Vacation/Sick leave [VERIFY COMPANY POLICY].

OR

☐ You do not have any PTO/Vacation/Sick leave [VERIFY COMPANY POLICY] available and your current leave is unpaid.

* If you are currently enrolled in healthcare benefits, and you are in an unpaid leave of absence, your benefits will end on DATE. [VERIFY COMPANY POLICY AND BENEFITS] COBRA information will follow under a separate cover at that time. [VERIFY POLICY - DELETE IF NOT APPLICABLE*]*
* At this time there are / there are no other options available to you under COMPANY’s policies. [BE SPECIFIC AND SPELL OUT WHAT IS AVAILABLE OR WHAT THEY HAVE ALREADY UTILIZED]
* You are solely responsible for providing updated FEHA/ADA Medical Certificates indicating your need for a continued accommodation. We also reserve our right to request an updated evaluation form from your health care provider on an as-needed basis. **Please be aware,** you must provide a new FEHA/ADA Medical Certificate, (see enclosed) before or on the date your current medical certificate expires. Your current medical certificate expires on DATE. [DATE THE CURRENT CERTIFICATE EXPIRES OR DATE OF COMPANY SPECIFIC DURATION FOR ONGOING LEAVE, SEE “PERIOD OF TIME” ABOVE]
* Employees returning from leave are required to provide COMPANY with a medical release to return to work form (see attached form). [VERIFY POLICY - DELETE IF NOT APPLICABLE]

If you have any questions about the FEHA/ADA or other 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]