**FEHA/ADA Accommodation Conditional Designation - Good Faith Meeting Letter (FDC1103)**

Send Certified and Regular Mail

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

DATE

EMPLOYEE NAME

ADDRESS

Dear EMPLOYEE NAME:

This letter confirms that COMPANY has received information, which may qualify you for benefits under the Fair Employment Housing/American’s with Disabilities Act (FEHA/ADA).

We received your  FEHA/ADA Essential Function Job Analysis - Health Care Provider form (FEHA/ADA Medical Certificate on DATE or  Written/Verbal request on DATE indicating the following work restrictions.

* [EXACT INFORMATION PROVIDED EITHER VERBALLY OR IN WRITING]

At this time, we require your assistance in clarifying if you are requesting COMPANY provide you an accommodation under the FEHA/ADA that will allow you to perform the essential functions of your job position without undue hardship to COMPANY.

It is our understanding:

You are unable to return to work until DATE and are requesting an accommodation to continue a temporary leave of absence with the intention of returning to work at a later designated date, as confirmed by your health care provider,

You are requesting an accommodation which would allow you to perform the essential functions of your current job or an alternative position, or

You do not intend to return to work and are not requesting an accommodation.

If you are either:

* Requesting an accommodation to continue a temporary leave of absence with the intention of returning to work at a designated date, as confirmed by your health care provider,

OR

* Requesting an accommodation which would allow you to perform the essential functions of your current job or an alternative position,

COMPANY requires additional documentation be provided to this office in order to facilitate an ongoing discussion regarding the above alternatives. We have enclosed our FEHA/ADA Essential Function Job Analysis, Health Care Provider Evaluation Form (FEHA/ADA Medical Certificate) to be completed by your health care provider 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 attached FEHA/ADA Medical Certificate.

**As a means of offering you every opportunity for protection under the FEHA/ADA, we are providing the following temporary accommodation(s) pending:**

* **Confirmation of your eligibility as a qualified individual with a disability,**
* **Receipt of the completed FEHA/ADA Medical Certificate, and**
* **Completion of the Good Faith Interactive Meeting scheduled below:**

[LIST ACCOMMODATIONS BE SPECIFIC AND DETAILED ABOUT ANY RELEVANT TIME LINES – Examples: Modification of, or Purchasing of Tools And Equipment, Modified Work Schedules (Such As Part-Time or Change In Hours), Job Restructuring, such as removal of specific tasks, Modification of The Work Environment, Alternative Position, Reduction of Physical Requirements such as Lifting, Walking, Sitting, Etc., and/or Time Off Work - IF PROVIDING LEAVE AS AN ACCOMMODATION INDICATE DAY LEAVE BEGIN AND EXPECTED RETURN TO WORK DATE]

* [ACCOMMODATION(S)]

Failure to provide the required documentation 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 scheduled a Good Faith Interactive meeting with you, NAME, TITLE, COMPANY and NAME ALL PARTIES ATTENDING, to discuss the FEHA/ADA accommodations on:

Date and Time –DATE & TIME [10 WORKING DAYS OR PRIOR TO THE MEDICAL CERTIFICATE EXPIRES]

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 INTERACTIVE 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: WORKERS’ COMPENSATION, COMPANY STD OR LTD OR OTHER COMPANY DISABILITY BENEFIT, AND OR STATE DISABILITY PROGRAM NAME, those benefits and PTO/Sick/Vacation leave pay [VERIFY COMPANY POLICY] 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 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 on-going health care provider certification 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 before or on the date the one currently on file 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 signed by your health care provider (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: TELEPHONE #

Enclosure: CA State Disability Insurance Information

FEHA/ADA Essential Function Job Analysis - Health Care Provider Evaluation Form

Certification of Health Care Provider for Employee Return to Work Form

Job Description [INCLUDE EXACT TITLE OF THE POSITION]

Authorization for Release of Medical Information [DELETE IF ALREADY RECEIVED]