**FEHA/ADA Accommodation Ended - Return to Work No Restrictions (FDC1113)**

Send Certified and Regular Mail

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

DATE

NAME

ADDRESS

Dear NAME:

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

* LIST OUT ACCOMMODATIONS

COMPANY received your FEHA/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.

Effective the date of your medical certificate listed above, it is our understanding that you can perform the full essential functions of the job without an accommodation. If this is not accurate, please have your Health Care Provider complete a new FEHA/ADA Essential Function Job Analysis - Health Care Provider Form to indicate what functions you can perform with or without and accommodation and return it to us. We will then initiate the FEHA/ADA Interactive Process with you at that time if you are requesting accommodations to perform the functions of your job. Please note we have provided the current Job Description for your review with your medical provider.

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

Name: NAME & TITLE

Phone: TELEPHONE NUMBER

Enclosure: Job Description

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