**FEHA/ADA Medical Certificate Clarification Request -**

**Good Faith Meeting Letter (FDC1107)**

Send Certified and Regular Mail

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

DATE

NAME

ADDRESS

Dear NAME:

On DATE we received an ADA Essential Function Job Analysis/Health Care Provider Analysis Form (ADA Medical Certificate) completed by your health care provider on DATE indicating your continued need for an accommodation under the Americans with Disabilities Act (ADA).

We understand you to have the following work restrictions:

* LIST RESTRICTIONS

COMPANY requires you to obtain additional information from your health care provider clarifying the questions listed below. Please provide the updated information no later than [DATE], seven (7) calendar days from the date of this letter. If you are unable to meet this deadline, you must notify us regarding any barriers to obtaining the information before the due date.

THE COMPANY requests your health care provider clarify the following attached medical certificate(s): [USE ONLY THOSE THAT APPLY TO THE SPECIFIC EMPLOYEE]

* We need more specific information about your restrictions as they relate to the primary functions of your job
* Whether you are able to return to work and/or continue to work with an accommodation,
* And if so, what accommodations would be required?
* We also need specific information from your health care provider regarding whether your disability poses a direct threat to the safety of you or others with and without the accommodation.
* Please provide the full extent of your restrictions in terms of how often, how long, and/or how much can you lift, for example, as it relates to [LIST SPECIFIC PHYSICAL REQUIREMENTS THAT NEED CLARIFICATION]
* If you are requesting leave as an accommodation, it is necessary to obtain your health care provider’s professional opinion of the full duration of the expected leave and a date they reasonably expect you to be able to return to work, with or without accommodation.

We have enclosed the FEHA/ADA Medical Certificate you submitted to us and a current job description for the position of [NAME OF POSITION]. Review the clarification request above and the attached job description with your health care provider. It is important that the health care provider specifically address the clarification issue(s) indicated above to assure that COMPANY NAME has enough information to confirm that the accommodation, as being represented by yourself, is medically required.

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

Date and Time – DATE & TIME [7 DAYS FROM DATE OF THIS LETTER]

Location – ADDRESS

Contact Name / Phone – NAME, NUMBER

Upon receipt of this letter, it is your responsibility to confirm your availability to attend the Good Faith Interactive meeting. You may return the ADA Medical Certificate on or before the meeting scheduled for GOOD FAITH MEETING DATE.

Please contact me if you have any questions regarding our request.

Name: NAME, TITLE

Phone: PHONE NUMBER

Enclosures:

1. FEHA/ADA Essential Function Analysis/Health Care Provider Form dated DATE [LIST EACH SEPARATELY IF THERE IS MORE THAN ONE]
2. Job Description [INCLUDE EXACT TITLE OF THE POSITION]
3. Authorization for Release of Medical Information[DELETE IF ALREADY RECEIVED]