American Airlines

REASONABLE ACCOMMODATION REQUEST – HEALTH CARE PROVIDER

Instructions: Employee should complete Sections 1 and 6. In addition, please ask your health care provider to complete Sections 2- 5. Please attach your job description to the request form

SECTION 1 – EMPLOYEE INFORMATION

Name		Employee Number		Home Telephone
Address		City	State	Zip
Department		City	Supervisor	Work Telephone
Current Position				

Employee Certification and Medical Release

I hereby authorize a health care provider representing American Airline to contact the undersigned health care provider for purposes of making disability related inquiries such as whether I have a disability, the need for any reasonable accommodation, and the nature of any such accommodation.

____ _______________________

Employee's Signature Date

SECTION 2 – DETAILS OF EMPLOYEE'S CONDITION

The employee identified above has requested a job accommodation from American Airlines. In order for the Company to properly evaluate the request, the following information is requested to help determine whether the employee has a disability.

Does the employee have a physical or mental impairment? ☐ Yes ☐ No

If yes, what is the impairment?____

What is the duration of the employee's impairment? ____

Does the impairment affect any of the following:
(Check any that apply)

☐ Caring for Self	☐ Walking	☐ Hearing	☐ Lifting
☐ Interacting with Others	☐ Standing	☐ Seeing	☐ Sleeping
☐ Performing Manual Tasks	☐ Reaching	☐ Speaking	☐ Concentrating
☐ Breathing	☐ Thinking	☐ Learning	☐ Operation of Bodily Function
☐ Working	☐ Sitting	☐ Eating	☐ Reacting
☐ Bending	☐ Reading		
☐ Other____			
☐ None of the above			

Does the impairment substantially limit the ability of the employee to perform any of the activities you identified as compared to most people in the general population? ☐ Yes ☐ No

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SECTION 3 – QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

Please see the attached job description to complete this Section.

What limitation(s), if any, interfere with the job performance or the employee's ability to access an employment benefit?

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How do the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access an employment benefit?

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SECTION 4 – QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

Do you have any suggestions regarding possible accommodations to enable the employee to successfully perform his/her job or access an employment benefit? If so, what are they?

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Would performing any of the job functions result in a direct safety or health threat to this employee or other people? Is there any other accommodation you would recommend which would eliminate this threat?

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SECTION 5 –TREATING HEALTHCARE PROVIDER INFORMATION

Health Care Provider's Name (Print)____

Today's Date________________ Type of Practice______________________ State (location) of Practice__________________________

Other Phone Number____ Office Fax____

Treating Health Care Provider's Signature____

SECTION 6–EMPLOYEE'S CERTIFICATION

I CERTIFY THAT ALL STATEMENTS AND ANSWERS PROVIDED BY ME OR MY HEALTH CARE PROVIDER ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION OF MY MEDICAL HISTORY OR REQUEST MAY BE CAUSE FOR DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION.

Employee's Signature ____ Date_____________________

Please give completed form to your Human Resources Business Partner