AMERICANS WITH DISABILITIES ACT (ADA) ACCOMMODATION REQUEST FORM

Date _____ **Name** _____ **Leave ID** _____

Employer Name: Terrebonne General Health System

Please complete this form to request an accommodation for a disability under the Americans with Disabilities Act (ADA) and/or analogous state law and return it to Cigna Leave Solutions (CLS). CLS services your employer's ADA program and any information you provide to CLS in connection with your ADA request will be shared with your employer.

NOTE: The federal Genetic Information Nondiscrimination Act of 2008 (GINA) and applicable state or local laws prohibit covered employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by such laws. To comply with such laws, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Job Title _____ **Employee ID** _____

Work Number _____ **Department** _____

Home Number_____ **City** _____**State** _____

Email address _____

Manager's Name_____ **Manager's Phone Number** _____

Complete this section for all requests

1) Are you requesting accommodation because of your *own* physical or mental impairment (as opposed to the medical need of a family member)? Check one: ☑ Yes ☐ No

2) Are you having difficulty performing your job duties due to your physical or mental impairment? If so, please describe the affected job duties and the difficulty you are having.

_____

_____

_____

_____

3) Are you experiencing challenges in other areas of your employment due to your physical or mental impairment? If so, please describe the challenges you are experiencing.

_____

_____

_____

4) What accommodations are you requesting, and how would such accommodations help you perform your job duties or address other challenges you are experiencing?

Exemption from the CMS COVID-19 vaccine mandate due to my serious health condition.

_____

_____

_____

5) How long will you require an accommodation? Check one: ☑ Permanently ☐ Temporarily ☐ Unknown

If temporary, what is the anticipated recovery date? _____

If you are requesting leave of absence as an accommodation, check the type of leave requested and complete the accompanying questions.

☐ Continuous Leave (leave for a single block of time)

- What is the time period for which you request continuous leave?

  Leave start date: _____ Leave end date: _____

☐ Reduced Work Schedule (a leave schedule that reduces your usual number of working hours per week or hours per workday)

- What is the reduced work schedule you are requesting (e.g., 4 hours per day, 3 days per week)?

  _____

- What is the time period for which you request a reduced work schedule?

  Reduced work schedule start date: _____Reduced work schedule end date: _____

☐ Intermittent Leave (leave taken in separate blocks of time)

- What is the estimated frequency and duration of the intermittent leave you are requesting? (*e.g., 1 day duration at a frequency of 5 times per month.*)

  Duration: _____ ☐ hour(s) OR ☐ day(s) (mark one)

  Frequency: _____ time(s) per ☐ week OR ☐ month (mark one)

- What is the time period for which you request intermittent leave?

  Intermittent leave start date: _____Intermittent leave end date: _____

_____ _____

Employee Signature Date

Please return to: Cigna Leave Solutions / P.O. Box 16163 / Pittsburgh, PA 15242-0791
Or Fax: 866.931.5095 or Email: FMLACertifications@Cigna.com

AMERICANS WITH DISABILITIES ACT (ADA) ACCOMMODATION REQUEST HEALTH CARE PROVIDER QUESTIONNAIRE

Date: _____ **Name**: _____ **Leave ID:** _____

Employer Name: _____

Your patient has requested an accommodation under the Americans with Disabilities Act (ADA) and/or analogous state law. When a disability and/or the need for accommodation is not obvious, an employer may ask for reasonable documentation from a health care provider about an employee's disability and functional limitations. **NOTE:** The federal Genetic Information Nondiscrimination Act of 2008 (GINA) and applicable state or local laws prohibit covered employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by such laws. To comply with such laws, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1) Does the patient have a physical or mental impairment for which an accommodation is recommended? ☐ Yes ☐ No

2) Does the impairment limit the patient's major life activities? *Major life activities include but are not limited to, instrumental activities of daily living such as caring for oneself and performing manual tasks; physical activities such as seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, etc.; and the operation of any major bodily system.*

   ☐ Yes ☐ No If yes, identify any major life activities limited by the patient's impairment.

   _____

   _____

3) Does the patient's impairment limit his/her ability to:

   a. Perform his/her job duties as described to you by your patient? ☐ Yes ☐ No. If yes, identify the affected job duties and describe and manner and degree of limitation in detail.

   _____

   _____

   _____

   b. Access benefits and other privileges of employment? *Examples include but are not limited to office parties at an accessible location, access to an employee cafeteria or parking, etc.* ☐ Yes ☐ No.

   If yes, identify the affected benefits/privileges and describe the manner and degree of limitation in detail.

   _____

   _____

4) How long do you expect the patient's impairment to last?
Check One: ☐ Unknown ☐ Permanent ☐ Temporary

If temporary, what is the anticipated recovery date? _____

5) What specific restrictions, if any, have you placed on the patient relevant to his/her employment and job functions?

_____

_____

6) What specific accommodations, if any, do you recommend that may enable the patient to overcome the limitations referenced above and enable the patient to perform his/her job functions and/or access benefits and other privileges or employment? Please explain how the suggested accommodation is likely to be effective in addressing the limitations.

_____

_____

_____

7) **If the patient is currently on leave**, could your patient return to work at this time if workplace accommodations are provided for the listed restrictions and/or limitations? ☐Yes ☐ No.
If no, explain why not.

_____

_____

_____

_____

8) **If you recommend leave of absence as an accommodation for the patient**, check the type of leave recommended and complete the accompanying questions.

☐ Continuous Leave (leave for a single block of time)

- What is the time period for which you recommend continuous leave?

  Leave start date: _____ Leave end date: _____

☐ Reduced Work Schedule (a leave schedule that reduces the usual number of working hours per week or hours per workday)

- What is the reduced work schedule you are recommending (e.g., 4 hours per day, 3 days per week)?
  _____
- What is the time period for which you recommend a reduced work schedule?

  Reduced work schedule start date: _____Reduced work schedule end date: _____

☐ Intermittent Leave (leave taken in separate blocks of time)

- If applicable, what is the estimated frequency and duration of intermittent leave recommended for **planned medical treatments including recovery time** and the start and end dates of same? (*e.g., 4 hours duration at a frequency of 2 times per month.*)
- Duration: _____ ☐ hour(s) OR ☐ day(s) (mark one)

  Frequency: _____ time(s) per ☐ week OR ☐ month (mark one)

  Start Date _____ End Date _____

- If applicable, what is the estimated frequency and duration of intermittent leave recommended for **episodic, incapacitating, and unforeseeable flare-ups, necessitating the employee to take leave from work** and the start and end dates of same? (*e.g., 2 days duration at a frequency of 1 times per week.*)
- Duration: _____ ☐ hour(s) OR ☐ day(s) (mark one)

  Frequency: _____ time(s) per ☐ week OR ☐ month (mark one)

  Start Date _____ End Date _____

Healthcare Provider Signature: _____

Name (Print): _____ **Specialty:** _____

Phone: _____ **Date:** _____

Please return to: Cigna Leave Solutions / P.O. Box 16163 / Pittsburgh, PA 15242-0791
Or Fax: 866.931.5095 or Email: FMLACertifications@Cigna.com