AMTRAK

EMPLOYEE/APPLICANT REQUEST FOR REASONABLE ACCOMMODATION

The purpose of this form is to assist Amtrak in determining whether, or to what extent, a reasonable accommodation is required to enable an employee/applicant with a disability or a pregnant employee to perform one or more essential functions of the employee's job. Information Amtrak obtains as part of this process will be maintained in accordance with applicable confidentiality requirements. Generally, requests for accommodation must be supported with medical documentation from the employee's healthcare provider. For more information about requesting a reasonable accommodation, please review Amtrak's policy here: https://allaboard.amtrak.com/s/article/Reasonable-Accommodation.

Employee/Applicant Name:	SAP Number (employees only):
Email:	
Phone Number:	
Job Title/ Job Applying to:	Today's Date:
Work Location (for example, Chicago Union Station, Wilmington Shops, OBS Long Distance):	New Request: ☐ Yes ☐ No If no, when was prior accommodation granted or request made:

Accommodation(s) Requested

Please state with specificity the accommodation(s) you are requesting. If there is more than one accommodation that you believe will meet your needs, please describe all possible accommodations.

Reason for Accommodation Request

Please describe the reason(s) why you are requesting an accommodation. Include a description of the essential function(s) of your job that you are unable to perform and explain how the requested accommodation(s) will enable you to perform the essential function(s) of your job.

Employee/ Applicant Signature: _____

NOTE: Please have your healthcare provider complete the Medical Assessment Form.

EMPLOYEE/APPLICANT REASONABLE ACCOMMODATION MEDICAL ASSESSMENT FORM
(To be Completed by Treating Healthcare Provider)

Patient Name: _____

The above employee/applicant further referred to as "the patient" has requested reasonable accommodation under the Americans with Disabilities Act (ADA), as amended, the Rehabilitation Act of 1973 or the Pregnancy Discrimination Act, to enable the patient to perform the essential functions of the patient's job, to be reassigned to a vacant job or for a medical leave of absence. The information requested on this form will enable us to make a determination regarding the employee's/applicant's request.

INSTRUCTIONS: This form must be completed and signed by the employee's/applicant's attending healthcare provider. Please attach additional pages and records as necessary. Do not provide information unrelated to the employee's/applicant's ability to perform their job duties. Failure to complete this form may result in the employee's/applicant's request being delayed or denied.

Question	Answer	
1. Please confirm that you have examined the patient and are familiar with their medical condition that precipitates the need for reasonable accommodation.	☐ Yes ☐No	
2. Does the patient have a physical or mental impairment?	☐ Yes ☐No	
If yes, what is the medical diagnosis associated with their impairment?		
3. Does the impairment substantially limit a major life activity?	☐ Yes ☐No	
If yes, mark the box with the major life activity(s) that is/are affected.	☐ Bending ☐ Breathing ☐ Caring for oneself ☐ Concentrating ☐ Eating ☐ Hearing ☐ Interacting with others ☐ Learning ☐ Lifting ☐ Performing manual task ☐ Reaching	☐ Reading ☐ Seeing ☐ Sitting ☐ Sleeping ☐ Speaking ☐ Standing ☐ Thinking ☐ Walking ☐ Working ☐ Other (please describe)
If yes, mark the box with the bodily function(s) that is/are affected.	☐ Bladder ☐ Bowel ☐ Brain ☐ Cardiovascular ☐ Circulatory ☐ Digestive ☐ Endocrine ☐ Genitourinary ☐ Hemic ☐ Immune	☐ Lymphatic ☐ Musculoskeletal ☐ Neurological ☐ Normal cell growth ☐ Operation of an organ ☐ Reproductive ☐ Respiratory ☐ Sensory organs & skin ☐ Other (please describe)

4. For the impairment(s) identified above, when did the patient's impairment(s) commence? If there is more than one impairment, please specify the start date for each.	
5. What is the duration of the accommodation requested? Please use your best medical judgement and current information to determine the length of time the patient will need an accommodation to perform the essential functions of their job. For example, identify the number of days, weeks, months, or years the patient would need the accommodation.	
6. Please confirm that you are familiar with the essential functions of the patient's job.	☐ Yes ☐No
7. Does the patient's impairment(s) limit the patient's ability to perform the essential functions of the job?	☐ Yes ☐No
If yes, identify which essential function(s) the patient is unable to perform without an accommodation and describe the limitations.	
8. Please describe the reasonable accommodation(s) that will enable the patient to perform the essential function(s) of the job. If you are requesting leave as an accommodation for the patient, skip to Question 11.	
9. Please describe how the accommodation(s) will assist the patient in performing the essential job function(s).	
10. Is the accommodation needed on an intermittent basis?	☐ Yes ☐ No
If yes, please describe the frequency and duration that the patient would need the accommodation. For example, please identify how many times per day, week, or month that the accommodation will be needed and how many hours or days the patient needs the accommodation on each occasion.	How often does the patient need the accommodation? _____ times per day/week/month How long does the patient need the accommodation on each occasion? _____hours/days
11. Is the request for a continuous leave of absence?	☐ Yes ☐No
If yes, please provide the anticipated return to work date and the likelihood that the employee will return on this date.	Anticipated Return-to-Work Date:_____ What is the likelihood the employee will return to work on the date listed above? _____ _____

12. Is the patient able to work in their current position and complete the essential functions of their position while the accommodation request is being processed? Please note that while we attempt to provide a determination regarding the request as timely as possible, there may be a period of time between the receipt of the request and when the determination is made.	☐ Yes ☐No
13. Are you aware of any other information that Amtrak should consider in assessing the patient's request for reasonable accommodation?	☐ Yes ☐No
If yes, please describe.	

Healthcare Provider's Signature _____ Date _____

Print Name and Phone Number or Office Stamp _____

If form is not completed by a Healthcare Provider, please state your job title.

Signature/Job Title _____ Date _____

Print Name and Phone Number _____

Email completed form and supporting documentation to: ADA@amtrak.com, fax to 202-799-6305

IMPORTANT INFORMATION REGARDING GINA

The Genetic Information Nondiscrimination Act (GINA) of 2008 prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members, except as specifically allowed by this law. In order to comply with this law, Amtrak is asking that you do 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 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.