

Employee Portion

Name: _____

Amazon Alias: _____ Date of Birth: ____/____/____

I authorize my healthcare provider completing this form, and my healthcare provider's agents and associates, to release medical information about me to Amazon, as needed to enable Amazon to evaluate whether and how my medical condition impacts my ability to perform my job duties and to further evaluate accommodations at work. I understand that Amazon will treat this medical information as a confidential medical record consistent with the Americans with Disabilities Act and any other applicable law. This authorization covers subsequent requests by Amazon for clarifying and obtaining additional information relevant to these subjects. I understand this authorization may expire under the laws of some states after I sign it, but I agree to extend my authorization as needed for these purposes.

Signature of Employee or Representative: _____

Relationship to Employee (if signed by representative): _____

Date Signed: ____/____/____

Healthcare Provider Portion**Below information (Sections 1 through 5) is to be completed by Healthcare Provider or their office only.**

For purposes of this form, the "employee" referenced throughout refers to your patient (name, date of birth above), who has requested reasonable accommodation related to their workplace or employment. The intent of this form is to establish that this employee has a qualifying disability or medical condition, and to identify duration, restrictions and/or limitations needed to evaluate the employee's request. Please complete all applicable portions of the form. If information is incomplete, Amazon will likely need to contact your office to complete the form.

Section 1: Medical Condition

Diagnosis is not required unless the underlying condition is related to pregnancy or childbirth, but diagnosis can be helpful in the interactive reasonable accommodation process.

California providers should not disclose a patient's diagnosis without their consent.

Diagnosis (not required to disclose): _____

Does the employee have a disability or medical condition that impacts their work?

☐ Yes. If yes, provide details as outlined within this form below.☐ No. If no, please explain how this accommodation request is connected to the employee's employment.Does this request concern a pregnancy or childbirth-related condition¹?☐ Yes (If employee is pregnant and has not yet given birth, provide expected date of delivery: ____/____/____)☐ No

Please answer this question only if the employee lives in Rhode Island: Does this request relate to menopause or pre-menopause² condition?

☐ Yes.☐ No.

¹ This information is needed because special rules apply to conditions related to pregnancy and childbirth. Such conditions include (but are not limited to) pregnancy, pregnancy loss, pregnancy-related and post-partum depression, menstruation, edema, morning sickness, pregnancy-related back pain, lactation, abortion and infertility treatment.

² This information is needed specifically for Rhode Island employees because of new law for menopause related symptoms

Section 1 Continued**Major Life Activities Impacted**

<u>Major Life Activity</u> Indicate the major life activity substantially impacted.	<u>Impact of Condition</u> Provide detail whether and how the medical condition(s) substantially impact major life activities.
☐ Sensory: Vision; Hearing; Speech; Other Sensory	Describe:
☐ Mobility: Gross Motor/Sitting Standing; Walking; Lifting; Fine Motor/Dexterity; Other Mobility	Describe:
☐ Medical: Immunocompromised; Medical Device; Personal Medical Treatment Administration; Other Medical	Describe:
☐ Executive Functioning/Neurodiverse: Concentration; Learning; Comprehension; Communication; Other Executive Functioning/Neurodiverse	Describe:
☐ Mental Health: Cognitive/Behavioral (memory, perception, expression, and/or environmental sensitivity); Social Setting / Interactions; Written or Verbal Interactions; Sensory or Other Triggers; Other Mental Health	Describe:
☐ Other:	Describe:

Section 2: Restrictions and Limitations

Describe the employee's job-related restrictions/limitations (e.g. cannot stand for more than X hours, distracted by noisy environments, lighting sensitivity). Explain specifically how the restrictions/limitations impact the employee's ability to perform their job duties or otherwise meet job-related requirements.

Restrictions/Limitations	Impact to Job Duties or Meet Job Related Requirements

Section 3: Accommodation Suggestion/Other Information

Amazon's interactive accommodation process considers the employee's condition, job duties, and business needs. Please use this section if you have specific suggestions for an accommodation or any other information to help us in evaluating an accommodation(s) for this employee.

Assistive technology or alternate formats (e.g., screen reader software, enlarged monitor, speech to text software, push pads for doors, alternate keyboard or mouse).

Describe:

Additional training (self), temporary job coach, or other individualized support

Describe:

Section 3: Accommodation Suggestion/Other Information – *Continued:***Changes to work duration/time/schedule**

☐ Specific Shift Availability	Provide details: <i>(e.g. between 6AM-3PM PST; or Unable to work overnight etc.)</i>
☐ Reduced Time	Provide details: <i>(e.g. no more than 36 hours of work each week)</i>
☐ No Mandatory Extra Time (hourly employees only)	Provide details:
☐ No Shift Bid (hourly employees only)	Provide details:
☐ Additional Breaks	Provide frequency and duration: <i>(e.g. 2 additional breaks each day; each break lasting up to 15 minutes)</i> _____ additional break(s) each shift with each break lasting up to _____ minutes.
☐ Intermittent Absences	Provide frequency and duration: <i>(e.g. 2 absences each month with each absence lasting up to 2 days)</i> _____ absence(s) each ☐ week, ☐ month, ☐ year with each absence lasting up to _____ ☐ hour(s) or ☐ day(s)
☐ Other	Provide details:

Changes to Work Environment

☐ Work Location	Describe:
☐ Workstation	Describe:
☐ Ramp Up	Describe: <i>(e.g. 1 day per week for 2 wks., then 2 days per week for 2 wks. Etc.)</i>
☐ Other	Describe:

Section 3: Accommodation Suggestion/Other Information – Continued:**Changes to Job Functions**

Restricted Job Function	Maximum Time in Hours Per Shift	Maximum Weight
☐ Lift/Carry ☐ Push/Pull	Describe specifics below:	Describe specifics below:
	Lift/Carry: _____ Hours Push/Pull: _____ Hours	Lift/Carry: _____ Push/Pull: _____
	_____ Hours _____ Hours	☐ Up to 5 pounds ☐ Up to 5 pounds
	_____ Hours _____ Hours	☐ Up to 15 pounds ☐ Up to 15 pounds
	_____ Hours _____ Hours	☐ Up to 25 pounds ☐ Up to 25 pounds
	_____ Hours _____ Hours	Other: _____
☐ Bending: ☐ Climbing (ladder/stairs/steps): ☐ Gripping: ☐ Reaching: ☐ Sitting: ☐ Squatting: ☐ Standing: ☐ Walking: ☐ Other:	Maximum time, if applicable	Describe Limitation below

Section 4: Accommodation Duration

Please identify the anticipated duration of the employee's restrictions/limitations. Please select if the restrictions are temporary, permanent or unknown duration:

☐ **Temporary**

☐ Anticipated Start Date: ____/____/____ to End Date: ____/____/____

☐ **Permanent**

☐ Anticipated Start Date: ____/____/____

☐ **Unknown/Indefinite:** Unable to predict end date with reasonable degree of certainty.

➤ If duration is unknown, please **identify an end date no later than 6 months from now**, when you may have updated information about the duration of the employee's restrictions/limitations:

➤ Anticipated Start Date: ____/____/____ to End Date: ____/____/____

Section 5: Healthcare Provider Signature and Contact Information

Please provide your stamp with information/signature here or complete the information below.

Healthcare Provider Name/Title: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date of Evaluation: ____/____/____