

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, the Pregnant Workers Fairness Act (PWFA), 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

The following sections (1 through 7) are to be completed by the healthcare provider or their office only.

For purposes of this form, the term "employee" refers to your patient (identified by name and date of birth above), who has submitted a request for reasonable accommodation related to their workplace or employment. The purpose of this form is to establish that the employee has a disability or medical condition, and to identify the duration, restrictions, and/or functional limitations necessary to evaluate the accommodation request.

Please complete all sections applicable to your patient's condition and accommodation request — you are only required to complete the sections relevant to your patient. Please note that if information is incomplete, Amazon will likely need to contact your office to obtain the necessary details to process the request.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information 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

Section 1: Medical Condition

Does the employee have a disability or medical condition that impacts their ability to perform their job functions?

☐ Yes- Please complete the relevant sections below, providing specific, measurable restrictions and their expected duration.

☐ No- If the employee does not have a disability or medical condition impacting their ability to perform their job functions, this form does not need to be completed.

Diagnosis is not required unless the underlying condition is related to pregnancy or childbirth¹, California providers should not disclose a patient's diagnosis without their consent.

Diagnosis: _____

Does this request concern a pregnancy or childbirth-related condition?

☐ Yes. (If employee is pregnant and has not yet given birth, provide expected date of delivery: ____/____/____)

☐ No.

Section 2: Major Life Activities Impacted

Select each major life activity affected by the employee's condition:

☐ Vision

☐ Hearing

☐ Speech

☐ Cognitive/behavioral (memory, perception, expression)

☐ Social interactions: Ability to engage in written or verbal communication, work in group settings, or manage sensory and emotional triggers in the workplace

☐ Concentration, learning comprehension

☐ Environmental Sensitivity

Duration/Frequency of Limitation:

☐ Constant — Limitation is present at all times

☐ Intermittent — Limitation occurs periodically or in episodes

☐ Temporary — Limitation is expected to resolve within a defined timeframe

☐ Permanent — Limitation is ongoing with no expected resolution

What specific limitations does this employee have in the selected major life activity?

How do these limitations affect the employee's ability to perform their job duties?

Section 3: Changes to work duration/time/schedule

☐ Shift Adjustments	Provide details:
☐ Reduced Time	Provide details: (e.g. no more than 36 hours of work each week)
☐ Additional breaks beyond standard breaks	Number of additional breaks needed per shift: ____ Length of each break (<i>complete only one</i>): • ____ minutes ____ hours
☐ Intermittent Absences	Number of absences needed (<i>complete only one</i>): • Per day: ____ • Per week: ____ • Per month: ____ Length of each absence (<i>complete only one</i>): • ____ minutes ____ hours ____ days

¹This 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.

Section 4: Changes to Job Functions

For each task, indicate whether the employee can perform it and for how long. If a task involves one side of the body, indicate Left (L), Right (R), or Both (B).

For each weight level in the Lift/Carry and Push/Pull tables below, enter the maximum hours per shift the employee can safely perform this task, or mark "X" if the employee cannot perform it at all.

Job Task (Please indicate if Left, Right, or Both sides)	Up to 5lbs	Up to 10lbs	Up to 15lbs	Up to 20lbs	Up to 25lbs	Up to 30lbs	Up to 40lbs	Up to 50lbs
Lift/Carry: ☐ Left ☐ Right ☐ Both								
Push/Pull: ☐ Left ☐ Right ☐ Both								

Upper Extremity Tasks

Task	Side (L/R/B)	Max Time (hours per shift)
Simple Hand Grip (≤ 15 lbs.)	☐ L ☐ R ☐ B	____ hrs
Forceful Hand Grip (> 15 lbs.)	☐ L ☐ R ☐ B	____ hrs
Overhead Reach	☐ L ☐ R ☐ B	____ hrs
At Shoulder Reach	☐ L ☐ R ☐ B	____ hrs
Below Shoulder Reach	☐ L ☐ R ☐ B	____ hrs

Body Positioning & Movement

Task	Max Time (hours per shift)
Bending/Twisting	____ hrs
Climbing (ladder/stairs/steps)	____ hrs
Sitting	____ hrs
Squatting	____ hrs
Kneeling	____ hrs
Standing	____ hrs
Walking	____ hrs

Note: Scheduled shift lengths vary (e.g., 8, 10, or 12 hours). If restrictions are better expressed as a percentage of total work hours or as continuous vs. cumulative time, please indicate below:

- ☐ Hours listed above are continuous (max time without a break from the task)
- ☐ Hours listed above are cumulative (total time across the full shift)

Additional notes: _____

Section 5: Changes to Equipment Operation

☐ Power Equipment (e.g. Powered Industrial Truck (PIT), Order Picker, reach truck)	Provide details:
☐ Work Vehicles (hostlers, trucks)	Provide details:
☐ Conveyor belts	Provide details:
☐ Handheld Scanner	Provide details:

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☐ Working from heights	Provide details: <i>Maximum permitted height, measured in feet</i>
☐ Other	Provide details:

Section 6: Other Changes

☐ Temperature Tolerance	Does the employee have temperature restrictions? ☐ Yes ☐ No If yes, indicate which apply: ☐ Maximum tolerable temperature: ____ °F ☐ Minimum tolerable temperature: ____ °F ☐ Both: Can work between ____ °F and ____ °F Additional context (e.g., duration of exposure, indoor vs. outdoor): _____
☐ Safety Equipment / Personal Protective Equipment (PPE)	Are there restrictions on wearing required safety equipment? ☐ Yes ☐ No If yes, indicate which apply: ☐ Safety shoes / steel-toed boots ☐ Metatarsal covers ☐ Safety glasses / goggles ☐ Hearing protection ☐ Hard hat ☐ Other: _____ Describe the restriction: _____
☐ Medical Device	Provide details:
☐ Changes to work environment (workstation set up)	Provide details:
☐ Gloves	Provide details:
☐ Elevator	Provide details:
☐ Other	Provide details:

Section 7: Accommodation Duration

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

☐ Temporary

Start Date: ____/____/____ to End Date: ____/____/____

☐ Permanent

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:

Start Date: ____/____/____ to End Date: ____/____/____

Healthcare Provider Signature and Contact Information

Please provide your professional stamp with information/signature here or complete the information below.	
Healthcare Provider Name/Title	
Specialty	Fax
Address	Phone
Signature	Date of Evaluation