Healthcare Provider Request for Information (RFI) Form - Operations

amazon | disability & leave services

Employee Portion

Name: Jordan Smith

Amazon Alias: jsmith88 Date of Birth: 05 /___/ 12/19

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[1], 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 condition?
[ ] Yes. (If employee is pregnant and has not yet given birth, provide expected date of delivery: ___/✓/_____)
[☑] No.

The patient has a persistent lumbar strain which significantly impacts their ability to perform daily work activities. Th

Section 1 Continued

Patient has a persistent lumbar

[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.

Major Life Activities Impacted

Major Life Activity Indicate the major life activity substantially impacted. Standing, Lifting, Carrying, Climbing, Mobility	**Impact of Condition** Provide detail whether and how the medical condition(s) substantially impact major life activities The patient suffers from significant mobility limitations due t
[ ]**Sensory**: Vision; Hearing; Speech; Other Sensory	Describe:
[✓]**Mobility**: Gross Motor/Sitting Standing; Walking; Lifting; Fine Motor/Dexterity; Other Mobility Standing, lifting, ca	Describe: The patient's persistent lumbar strain results in significant m
[✓]**Medical**: Immunocompromised; Medical Device; Personal Medical Treatment Administration; Other Medical	Describe: The patient requires two 10-minute breaks per shift to perfor
[ ]**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:** Climbing	Describe: The patient has been advised to avoid all climbing of ladder

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/Requirements
Persistent lumbar strain with significant	The restrictions on standing, lifting, and climbing impact the employee's ability to p

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: Requires 2 additional breaks, each lasting no more than 10 minutes, to perform required spinal decompression stretches.

Section 3: Accommodation Suggestion/Other Information – *Continued*:

Changes to work duration/time/schedule

[ ] Specific Shift Availability	Provide details: *(e.g. between 6AM-3PM PST; or Unable to work overnight etc.)*
[ ] Reduced Time Requires two additional breaks per s	Provide details: *(e.g. no more than 36 hours of work each week)* Requires 2 additional breaks per shift, each lasting no more than 10 minutes, to perfo
[ ] No Mandatory Extra Time (hourly employees only)	Provide details:
[ ] No Shift Bid (hourly employees only)	Provide details:
[ ] Additional Breaks Yes	Provide frequency and duration: 2 breaks, each lasting no more than 10 minutes, to *(e.g. 2 additional breaks each day; each break lasting up to 15 minutes)* 2 additional break(s) each shift with each break lasting up to 10 minutes.
[✓] Intermittent Absences Patient requires 2 additional breaks	Provide frequency and duration: Patient requires 2 breaks per shift, each lasting up t *(e.g. 2 absences each month with each absence lasting up to 2 days)* 2 absence(s) each [ ]week, [ ]month, [ ]year with each absence lasting up to _____ [ ]hour(s) or [ ]day(s) 10 minutes
[ ] Other Additional breaks for medi Requires two additional 10-minute b	Provide details: Requires 2 additional breaks throughout the shift, each lasting no mo

Changes to Job Functions

Restricted Job Function	Maximum Time in Hours Per Shift	Maximum Weight 15
[✓]Lift/Carry **[ ]**Push/Pull	Describe specifics below: Cannot lift or c	Describe specifics below: Cannot lift or carr
	Lift/Carry: Push/Pull:	Lift/Carry: 15 Push/Pull:
	_____Hours _____Hours	**[ ]** Up to 5 pounds **[ ]** Up to 5 pounds
	_____Hours _____Hours	**[✓]** Up to 15 pounds **[ ]** Up to 15 pounds
Cannot lift or carry objects weighing 0	✓ Hours _____Hours	**[ ]** Up to 25 pounds **[ ]** Up to 25 pounds
	Restricted to no more than 2 hours of sta	
	_____Hours _____Hours	Other:
	Maximum time, if applicable	Describe Limitation below
[ ] Bending:		
[ ] Climbing (ladder/stairs/steps):		
[ ] Gripping:		
[ ] Reaching:		
[ ] Sitting:		
[ ] Squatting:		
[ ] Standing:		
[ ] Walking:		
[ ] Other:		

Changes to Equipment Operation

[ ]Power Equipment *(e.g. forklift, reach truck, scissor lift, etc.)*	Describe:
[ ]Vehicles *(e.g. van, truck)*	Describe:
[✓]Working From Heights Advised to avoid a	Describe: Advised to avoid all climbing of ladders or stairs during this recover
[✓]Other Equipment Ladders	Describe: Avoid all climbing of ladders.

Section 3: Accommodation Suggestion/Other Information – *Continued:*

Other Changes Patient is restricted to no more than 2 hours of standing per shift and cannot lift or carry objects weighing mo

[ ]Working in extreme temperatures *(e.g. freezer)*	Describe:

[ ]Safety equipment *(e.g. safety shoes, gloves, other)*	Describe:
[ ]Other Avoid all climbing of ladders or stai	Describe: Due to a persistent lumbar strain, the patient has been advised to a

Changes to Work Environment (work location or workstation set up)

Describe:

Employee is restricted to no more than 2 hours of standing per shift and cannot lift or carry objects weighing mor

Section 4: Accommodation Duration

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: ___/___/02/01 to End Date: ___/___/05/31
- [ ] 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 professional stamp with information/signature here or complete the information below.

Dr. Elena Rodriguez, MD, Orthopedics 123 Wellness Way, Suite 400 Springfield, IL 62704 Phone: 555-0199 Fax: 555-019

Healthcare Provider Name/Title: Dr. Elena Rodriguez, MD Specialty: Orthopedics

Address: 123 Wellness Way, Suite 400, Springfield, IL 62704

Phone: 555-0199 Fax: 555-0198

Signature: Dr. Elena Rodriguez Date of Evaluation: ___/___/01/15