



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 his or her job. The information will be treated confidentially to the greatest extent possible. Generally, requests for accommodation must be supported with medical documentation from the employee's or applicant's healthcare provider.

Employee / Applicant Name: SAP Number:

Job Title: Employee / Applicant Phone:
Union (if applicable): Employee / Applicant Email:
Department: Employee / Applicant Address:
Supervisor / Manager: 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:

What are the essential functions of this position?

Please state with specificity the accommodation you are requesting.
Employee / Applicant Signature:
NOTE: Please have your healthcare provider complete the attached Medical Assessment form.

To be completed by the Reasonable Accommodation Panel only:
Accommodation request is:
Approved
Denied
Modified
Date Determination Made:
If modified, describe modification. If denied, give rationale.
Date Medical Assessment Received:
Disability Program Manager Signature: Date:

**EMPLOYEE / APPLICANT REASONABLE ACCOMMODATION MEDICAL ASSESSMENT FORM
(To be Completed by Treating Physician)**

Employee / Applicant / Patient Name:

The above employee / applicant / 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 him/her to perform the essential functions of his / her position, to be reassigned to a vacant position or for a medical leave of absence. The information requested on this form will enable us to make a determination regarding the employee's or applicant's request.

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

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. 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 member's medical history, the results of an individual's or family'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 family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Please confirm that you have examined the employee / applicant and are familiar with the employee's or applicant's medical condition that precipitates the need for reasonable accommodation. Yes No

2. Please provide the medical diagnosis associated with the impairment(s) for your patient.

3. Please confirm that you are familiar with the essential functions of the employee's or applicant's position or proposed position.

Yes No

EXISTENCE OF IMPAIRMENT

4. Does the employee / applicant have a physical or mental impairment? Yes No

5. If the answer to No. 3 is "yes", does the impairment substantially limit a major life activity?

Yes No

LIMITATIONS ON MAJOR LIFE ACTIVITIES

6. If the answer to 4 is “Yes”, which major life activity is / are affected? Please check all major life activities that both (a) substantially affected by the employee’s impairment and (b) restrict or limit the employee’s ability to perform his / her job duties.

Major life activities – general life activities

Bending Breathing Caring for oneself Eating Hearing	Interacting with others Learning Lifting Performing manual tasks	Reaching Reading Seeing Sitting Sleeping Speaking	Standing Thinking Walking Working Other (please describe)
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Major life activities - Operation of major bodily functions

Bladder Bowels Brain Cardiovascular Circulatory	Digestive Endocrine Genitourinary Hemic Immune	Lymphatic Musculoskeletal Neurological Normal cell growth Operation of an organ	Reproductive Respiratory Sensory organs & skin Other(s) (describe)
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COMMENCEMENT OF IMPAIRMENT(S)

7. For the impairments identified above, when did the employee’s or applicant’s impairment(s) commence? If there is more than one impairment, please specify the start date for each:

PERFORMANCE OF ESSENTIAL JOB FUNCTIONS

8. Does the employee’s / applicant’s impairment(s) limit his/her ability to perform the essential functions of his / her position?

Yes No

a. If the answer is yes, identify which essential function(s) the employee or applicant is unable to perform without an accommodation and describe the limitations:

9. ACCOMMODATION(S)

Please describe

a. Reasonable accommodation(s) that will enable the employee / applicant to perform the essential functions of the job:

b. How the accommodation(s) will assist the employee / applicant in performing the essential job functions:

10. DURATION

For how long do you anticipate the employee / applicant will need the identified accommodation to perform the essential job functions?

NOTE: You must provide your best medical judgment, based on current information, as to the length of time the employee / applicant will need an accommodation to perform his / her essential job function(s).

Days

Weeks

Months

Years

Permanent

Other Comments:

11. OTHER INFORMATION

Are you aware of any other information that Amtrak should consider in assessing the employee's or applicant's request for reasonable accommodation? Yes No
If yes, please describe.

Physician's Signature

Date

If form is not completed by a physician, please state your role.

Signature/Role

Date

Email completed form and supporting documentation to: MedicalServices@amtrak.com, fax to 215-349-4401, or mail to Amtrak Medical Services, 2955 Market Street, 30th Street Station, Box 67, Philadelphia, PA 19104.