American Airlines

REASONABLE ACCOMMODATION REQUEST FORM

This form has two sections that need to be completed:

One section to be completed by the employee and
One section to be completed by the health care provider

Please give completed form to your Human Resources Business Partner

TO BE COMPLETED BY THE EMPLOYEE

Today's Date_________________

SECTION 1 - EMPLOYEE INFORMATION	
Employee Name	
Employee Number	
Employee Contact Phone	
Employee Mailing Address	
Employee Email Address	
Base Location (include city & state)	
Manager Name	

Work Group	
☐ Fleet Service (Ramp, Cargo, etc.)	☐ Non-contract (Mgt., Admin.)
☐ Flight Attendants	☐ Passenger Service - Airports
☐ Flt. Ops Pilot	☐ Pilot
☐ Flt. Ops Other (FCTI, Sim Engineer, Dispatch, etc.)	☐ Reservations
☐ Tech Ops	

SECTION 2 – QUESTIONS TO CLARIFY ACCOMMODATION REQUESTED	
Accommodation Start Date	
Accommodation End Date (Indicate "Indefinite" if requesting an indefinite modification.)	

A. Questions To Clarify Accommodation Requested.

What specific accommodation are you requesting?

If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore?	☐ Yes ☐ No

If yes, please explain.

Is your accommodation request time sensitive?	☐ Yes ☐ No

If yes, please explain.

B. Questions To Document The Reason For Accommodation Request.

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What, if any, job function are you having difficulty performing?

Have you had any accommodations in the past for this same limitation?	☐ Yes ☐ No

If yes, what were they and how effective were they?

If you are requesting a specific accommodation, how will that accommodation assist you?

Other: Please Provide Any Additional Information That Might Be Useful In Processing Your Accommodation Request.

SECTION 3 – GINA Compliance Notice:

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 employees or their family members. In order to comply with this law, we are asking that you not request or 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 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 4 – IMPORTANT INFORMATION

American Airlines will review and respond to your job accommodation request as soon as feasible. If you have questions in the meantime, please contact your Human Resources Business Partner.

SECTION 5 – SIGNATURES

I certify that all statements and answers provided on this form are complete and true to the best of my knowledge, and I understand that any falsification of my medical history or request may be cause for disciplinary action up to and including termination.

Employee Signature	
Date	

Send completed form to your Human Resources Business Partner

SECTION 6 - Employee Certification and Medical Release

I hereby authorize a health care provider representing American Airline to contact the undersigned health care provider for purposes of making disability related inquiries such as whether I have a disability, the need for any reasonable accommodation, and the nature of any such accommodation.

Employee Signature	
Date	

American Airlines

REASONABLE ACCOMMODATION REQUEST FORM
TO BE COMPLETED BY THE HEALTH CARE PROVIDER

SECTION 1 - EMPLOYEE INFORMATION	
Employee name	
Employee AA personnel number	
Employee Contact Phone	
Employee Mailing Address	
Employee Email Address	

SECTION 2 – DETAILS OF EMPLOYEE'S CONDITION

The employee identified above has requested a job accommodation from American Airlines. In order for the Company to properly evaluate the request, the following information is requested to help determine whether the employee has a disability.

Does the employee have a physical or mental impairment? ☐ Yes ☐ No

If yes, what is the impairment?

What is the duration of the employee's impairment?

Does the impairment affect any of the following (Check any that apply):

☐ Caring for Self	☐Walking	☐Hearing	☐Lifting
☐Interacting with Others	☐Standing	☐Seeing	☐Sleeping
☐Performing Manual Tasks	☐Reaching	☐Speaking	☐Concentrating
☐Breathing	☐Thinking	☐Learning	☐Operation of Bodily Function
☐Working	☐Sitting	☐Eating	☐Reacting
☐Bending	☐Reading		

☐Other

☐None of the above

Does the impairment substantially limit the ability of the employee to perform any of the activities you identified as compared to most people in the general population? ☐ Yes ☐ No

SECTION 3 – QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

Please see the attached job description to complete this Section.

What limitation(s), if any, interfere with the job performance or the employee's ability to access an employment benefit?

How do the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access an employment benefit?

SECTION 4– QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

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Do you have any suggestions regarding possible accommodations to enable the employee to successfully perform his/her job or access an employment benefit? If so, what are they?

Would performing any of the job functions result in a direct safety or health threat to this employee or other people? Is there any other accommodation you would recommend which would eliminate this threat?

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SECTION 6 –TREATING HEALTHCARE PROVIDER INFORMATION

Health Care Provider's Name (Print)	
Today's Date	
Type of Practice	
State (location) of Practice	
Phone Number	
Office Fax	
Treating Health Care Provider's Signature	

SECTION 7 – INTERNAL USE ONLY

Date Received	
Forwarded to (Name)	Date forwarded