Accommodation Request

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Based on your disability, this form will help us identify a job accommodation so you can perform the essential functions of your job or complete the interview/testing process.

Part 1 - To be fully completed by Employee or Job Applicant and return to Supervisor. Please do not share medical details on this form. Submit to workplaceaccommodationsteam1@verizon.com or submit via secure fax to 1-866-315-9615.

1. Sign the Medical Authorization (Part 2) and submit it to the Workplace Accommodations Team.
2. Give the Medical Questionnaire (Part 3) and Medical Authorization (Part 2) to your Health Care Provider.

Employee or Job Applicant Name:	**Employee ID** (available in Verizon e-Directory)
Employee /Job Applicant work address, including city and state: **Employee Home /Cell phone Number:** **Personal Email:**	☐ **Union** ☐ **Non-Union or Management**

Current Employees Only: What specific job tasks are problematic for you?

Current Employees and Job Applicants: Please identify the workplace arrangement that you are requesting (either in the current job or during the interview/testing process).

If your doctor has suggested possible ergonomic/adaptive technology that would assist you in performing your essential job functions (for example, office equipment or modifying a work station to better suit your needs), please mark all of the following that apply:

☐ Chair ☐ Headset ☐ Keyboard ☐ Input Device such as a mouse ☐ Monitor ☐ Magnifying Screen /Monitor

☐ Sit-Stand ☐ Foot Stool ☐ Other Adaptive Equipment (Describe): _____

Describe how this accommodation will help you to either:
(1) Perform the essential functions of your job or (2) Complete the interviewing/testing process:

Current Employees Only:
Indicate how long this accommodation will be required: _____

You are required to provide any supporting material from your Health Care Provider (HCP) supporting this request. According to federal law regarding privacy of medical records, your HCP may require your authorization prior to furnishing medical information to Verizon. It is your responsibility to work with your HCP in order to ensure that he/she provides your medical information to Verizon so that a decision can be made regarding your request. Please sign the attached Medical Authorization Form (Part 2) so the Workplace Accommodations Team can contact your HCP regarding your request for accommodations.

Initial to acknowledge you have read the above: _____

Employee / Applicant Signature (or preparer's signature if verbal) NOTE: Typed name will be accepted as signature.	**Date**

SUPERVISOR / RECRUITER INFORMATION	
Name (Last, First, MI)	
Office Phone Number	Office E-mail Address
Supervior/RecruiterSignature:	

For questions contact the Workplace Accommodations Team at **1-877-635-1231** or **workplaceaccommodationsteam1@verizon.com**.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entitles 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 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 members' genetic tests, the fact that an individual or an individual's family member sought or received genetic Services, and the 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 received assistive reproductive services.

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Employee Action:
Part 2 – Sign this Medical Authorization, and submit to the Workplace Accommodations Team at workplaceaccommodationsteam1@verizon.com or FAX to 1-866-315-9615. You can include any related medical records.

Additionally, in order to medically substantiate the request, you may be required to submit detailed medical records including, as applicable, office visit notes, exam findings, evaluations, test results (such as lab work, x-rays and diagnostic studies), restrictions and limitations (potentially a list of physical capabilities) related to your job restriction/accommodation request.

Provide Part 3 to your health care provider and have your provider complete Part 3 – the Medical Questionnaire. You or your provider should EMAIL the completed Medical Questionnaire form to the Workplace Accommodations Team at workplaceaccommodationsteam1@verizon.com or FAX to 1-866-315-9615.

Verizon Workplace Accommodations Team
One Verizon Way
Basking Ridge, NJ 07920
EMAIL: workplaceaccommodationsteam1@verizon.com
FAX: 1-866-315-9615
Questions? Call 1-877-635-1231

Authorization to Disclose Information About Me

For purposes of administering my request for job restrictions and/or accommodation(s), I permit and authorize: any physician, other medical/treating practitioner, hospital, clinic or other medical-related facility/service (and any medical consultants or examiners that may be retained in connection with my request for job restrictions/accommodations) to disclose to the Verizon Workplace Accommodations Team ("WPAT"), in its capacity as evaluator of my request for job restrictions/accommodations, any and all information concerning my job restriction/accommodation request and medical care that is related to this job restriction/accommodation request.

I understand that Sedgwick Claims Management Services ("Sedgwick") performs advisory services to WPAT to enable WPAT to determine if my request for job restrictions and/or accommodations is medically substantiated. **For purposes of performing such advisory services,** I authorize any physician, other medical/treating practitioner, hospital, clinic or other medical-related facility/service (and any medical consultants or examiners that may be retained in connection with my request for job restrictions/accommodations) to disclose to Sedgwick, upon request, any and all information concerning my job restriction/accommodation request and medical care that is related to this job restriction/accommodation request.

WPAT and/or Sedgwick, in their respective capacities and for the purposes set forth above, are authorized to use any information relevant to my request for job restrictions and/or accommodations that may be contained in any file maintained by Sedgwick related to a claim made by me for Worker's Compensation benefits or for any group disability income benefits under a Verizon plan.

This form specifically grants my permission to disclose medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological conditions; and alcohol or drug abuse (including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws) with the specific exception of psychotherapy notes.

Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses might be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to re-disclosure by the recipient and may no longer be covered by those rules.

I understand that I may revoke this authorization at any time by writing to both the Verizon Workplace Accommodations Team, One Verizon Way, Basking Ridge, NJ 07920 and Sedgwick, P.O. Box 14192, Lexington, KY, 40512-4192(Fax: 1-859-264-4384), except to the extent that action has been taken in reliance on it by either party before such party's receipt of my revocation. If I do not, this authorization will be valid for 18 months from the date I sign this form or the duration of my request for job restrictions/accommodations, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

_____ _____
Printed Name of Employee or Applicant: **Employee ID or Enterprise:**

_____ _____
Signature of Employee: **Date:**

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Part 3 – Medical Questionnaire - To be completed by Health Care Provider

Employee Name:
Employee Identification:
WPA Case #:

Health Care Provider:
Your patient has indicated that a medical condition is impacting his/her ability to perform the essential functions of his/her job and provided a signed medical authorization. This form requests supporting information and documentation. Answer all questions to a reasonable degree of medical probability. If no job description is attached, please discuss the position with your patient to identify which of the job tasks he/she is substantially limited in performing due to a medical condition.

Send To:
Verizon Workplace Accommodations Team Secure fax: 1-866-315-9615 or email **workplaceaccommodationsteam1@verizon.com**

For questions contact:
Verizon Workplace Accommodations Team at **1-877-635-1231** or email **workplaceaccommodationsteam1@verizon.com**

1. Identify possible workplace arrangements that would assist the employee in performing his/her job, including ergonomic or adaptive technology if applicable.

2. Does the employee have a physical or mental impairment? Yes___ No___

   If *yes*, please describe the impairment:

   What major bodily functions are affected?

3. What is the medical condition(s) causing the need for accommodation?

4. Does the employee's impairment substantially limit any of the following major life activities:

__ Working	__ Interacting with others	__ Seeing	__ Thinking
__ Bending	__ Learning	__ Self-Care	__ Walking
__ Breathing	__ Lifting more than____lbs	__ Sitting	__ Other (describe)
__ Concentrating	__ Performing manual tasks	__ Sleeping	
__ Eating	__ Reaching	__ Speaking	
__ Hearing	__ Reading	__ Standing	

5. For each major life activity that is limited by the impairment, please describe *the limitations*:

6. What is the expected duration of the employee's impairment?

7. What, if any, medication regimen/ongoing treatment plan is the employee currently under with respect to the medical condition causing the need for accommodation, that will allow the employee to perform their essential job functions? What is the duration of the any regimen/ongoing treatment?

8. How do these conditions affect the employee's ability to perform his/her essential job functions?

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9. Please review the attached job description. Is the employee able to perform all job functions? Yes___ No___

   If *no*, which job functions cannot be performed and why?

10. Would performing any of the job functions noted result in a direct safety or health threat to the employee or others?

    Yes___ No___ If *yes*, please describe:

    Job functions that pose a threat:

    Describe the nature of the safety or health threat posed:

11. If workplace accommodations are recommended state the start date and end date.

    Accommodations Start Date: _____ Accommodations End Date: _____

12. If your opinion is that this employee is unable to work at all at this time and requires medical leave, please provide duration.

    Leave Start Date: _____ Leave End Date: _____

13. If your opinion is that this employee is able to work but requires medical leave on an intermittent basis, please provide the reason, frequency and duration of leave that would be required.

    Are these intermittent absences predictable?

14. Do you recommend that the employee work less than full schedule as a result of the condition?
    ☐ YES ☐ NO

    If yes, please provide a recommended schedule and state the probable duration that the employee will require such a schedule.

Telephone Number: _____ Physician/Provider Print Name: _____

Fax Number: _____ Physician/Provider Title/Specialty: _____

Email Address: _____ Physician/Provider Signature: _____

Date Completed: _____

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