ADA Accommodation
Guide to the Interactive Process

Employee name: ____________________________________________ Employee ID No.: ____________________

Employee position: ___________________________ Employee Location: ________________________________

Process supervised by: ___________________________ Position: ________________________________

Participants: ________________________________________________

NOTES:

A. Document every step in this process, including discussions, information gathered, and decisions.

B. The purpose of the interactive process is to identify an accommodation that is reasonable and effective, and does not impose an undue hardship on the employer.

C. The interactive accommodation process must be flexible and suited to the employee’s and employer’s situations. This Guide is intended as an aid to the process and not a set of rules.

D. In many cases the employee’s disability and limitations are relatively obvious and it is simple to identify an appropriate accommodation, and/or to determine that the identified accommodation will not impose an undue hardship. In such event the employer does not have to – and should not – complete every step of the process outlined below.

E. Once an accommodation is determined and implemented, be sure to document the decision reached. Then, monitor the effectiveness of the accommodation periodically after its implementation.

F. The employer’s accommodation obligation is ongoing. If an accommodation is no longer effective (e.g., if the employee’s condition changes) the employer has the obligation to engage in the ADA interactive process again to determine whether a change of the accommodation is warranted.

INTERACTIVE ACCOMMODATION PROCESS:

1. Accommodation request received or accommodation identified:

   a. Date received: ______________________________________________

   b. Who made the request or identified the need? ____________________________

   c. Description of accommodation: ________________________________________
c. Method of request (written, phone, in person, etc): ______________________________________

d. Type of accommodation requested: ______________________________________________________
    ______________________________________________________________________________________

2. **Initiate communications with employee.**

   a. Date: __________________________________________

   b. Does the employee have a disability? If so, what is it: __________________________________
    ______________________________________________________________________________________

   c. What limitations or restrictions does the disability impose on the employee? __________
    ______________________________________________________________________________________
    ______________________________________________________________________________________
    ______________________________________________________________________________________

   d. Anticipated duration of the limitations: _______________________________________________

   e. Essential functions of employee’s position (attach job description or similar):

      i. Per existing job description: __________________________________________________________
         __________________________________________________________________________________

      ii. Opinions of essential functions as actually performed in the workplace:
         Employee: _________________________________________________________________________
         __________________________________________________________________________________
         __________________________________________________________________________________

         Employee’s supervisor: _______________________________________________________________
         __________________________________________________________________________________
         __________________________________________________________________________________

         Human resources: __________________________________________________________________
         __________________________________________________________________________________
         __________________________________________________________________________________
Determination of essential functions: ______________________________________

____________________________________________________________________

____________________________________________________________________

iii. How do the employee’s limitations or restrictions affect the employee’s ability to
perform the essential and/or marginal functions of his/her position? __________

____________________________________________________________________

3. Is medical documentation needed to identify or substantiate the employee’s disability, limitations,
and effective accommodations? If so, check each step below when completed:

a. Is the employee’s disability/impairment and need for an accommodation obvious?
Yes_______ No_______ If yes, do not request medical information.

b. ______ Provide ADA Medical Assessment Form and medical authorization form to
employee. (Include GINA language on each.)

c. ______ Obtain employee’s signature on medical authorization form.

d. ______ Notify employee of deadline for return of medical forms, and explain the
consequences of failure to return the form. Due date: __________________________

4. Assess medical information when received:

a. Does medical information support the existence of disability and need for an
accommodation? Yes_________ No_________ Explain: __________________________
b. Is clarification or supplementation is needed? Describe: ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
c. Discuss medical information with employee, even if answer to Question 4.a., above, is “No”.
   Date:__________________ Participants: __________________________________________________________
d. Contact with employee’s health care provider:
   i. Provide employee with letter to provider for clarification or supplementation if
      necessary. N/A:_____--OR-- Due date for return of information: __________________________
      --OR--
   ii. Has employee granted permission to contact provider directly:
      No_________ Obtain medical information only through employee.
      Yes_____ Is medical authorization signed by employee? Yes______ No _______
      Describe contact with medical provider (date, name, content of conversation): __
      ________________________________________________________________
      ________________________________________________________________

5. Based on the medical and other pertinent information received, discuss with employee:

   a. Date of discussion:_________Participants: ______________________________________________________
      Content of discussion: _________________________________________________________________
      ________________________________________________________________
      ________________________________________________________________

6. Accommodation suggestions: For each suggested accommodation under consideration, identify
   whether it is:

   — Reasonable:  Plausible or feasible in the ordinary course of things.
   — Effective:  Enables the employee to perform the essential functions of the job.
— **Imposes an Undue Hardship:** Creates a significant difficulty or expense (unduly extensive, substantial, disruptive, or would fundamentally alter the nature of the business operation). Include specific facts, amounts, and considerations as evidence of undue hardship. Generalities and assumptions are not adequate.

— Use additional pages and attach supporting documentation if necessary.

a. Accommodation suggestion and analysis: ________________________________

   Reasonable: ________________________________

   Effective: ________________________________

   Undue hardship: ________________________________

b. Accommodation suggestion and analysis: ________________________________

   Reasonable: ________________________________

   Effective: ________________________________

   Undue hardship: ________________________________

7. **The accommodation determination.**

   a. Employer’s preferred accommodation and reasons: ________________________________

   ________________________________

   b. Employee’s preferred accommodation and reasons: ________________________________

   ________________________________

   c. Decision and reasons: ________________________________

   ________________________________

   ________________________________
d. Discuss and communicate the decision to the employee. Date: ____________________

Participants: ________________________________

Content of discussion: ________________________________

_________________________________________________

_________________________________________________

_________________________________________________

8. Implementation plan:

a. Date of implementation: ________________________________

b. Anticipated duration of accommodation: ________________________________

c. Notification to and discussion with

i. Employee’s supervisor: __________________ Date: ______________

Comments/discussion: ________________________________

_________________________________________________

ii. Human resources representative: ______________Date: ________________

Comments/discussion: ________________________________

_________________________________________________

9. Follow up and monitor.

a. Follow up shortly after implementation of the accommodation. Date: ______________

   Is accommodation effective? Any problems? Results/discussion with employee: __________

   __________________________________________________

   __________________________________________________

b. Schedule for periodic follow—up: Is accommodation still effective ad not an undue hardship?

   i. Date: ______________ Comments: ________________________________
ii. Date: __________ Comments: ____________________________________________

iii. Date: __________ Comments: ____________________________________________

10. Leave as an accommodation – special considerations:

a. Expected return-to-work date: ____________________________________________

b. Date for employee to confirm RTW date: __________________________________

c. Follow-up/monitoring: Employee may be required to provide status reports periodically
during leave if required by employer’s general leave of absence policies. Instructions to
employee for status reports (dates/frequency): __________________________________
__________________________________________

__________________________________________

d. Is employee able to end leave and return to work with a workplace accommodation (e.g.,
modified schedule, special equipment, or relief from marginal duties)? ________________
__________________________________________

11. Consider an interim/temporary accommodation – if it will take time to gather information and
appropriately evaluate suggested accommodations, an interim accommodation may be in order.

a. Examples: modified schedule, temporary leave, temporary change in equipment, furniture,
or workspace

b. Reason: avoid having employee in an unsafe or unproductive situation, or subject to co---
worker issues

12. Does the employee present a direct threat of harm to himself or others? Factors to consider

(attach documentation, if available):

What is the specific risk? ________________________________________________

How significant and probable is the risk? ___________________________________

What is the expected duration of the risk? _________________________________
What specific harm could result from the risk? 

Is the threat of harm substantial, serious and imminent? Describe: 

Can the risk or the harm be reduced by a reasonable accommodation? If yes, what accommodation? (Follow above accommodation process if needed.)