PERSONAL AND CONFIDENTIAL
INTERACTIVE PROCESS CONSULTATION/MEETING NUMBER _____
TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT REPRESENTATIVE AND SIGNED BY EMPLOYEE

Employee Name: _____

Employee Hire Date:_____

Job Title: _____

Department/Location: _____

Shift/Hours of Work:_____

Supervisor/Manager:_____

Interactive Process Consultation Date/Time:_____

Interactive Process Consultation Conducted: ____ In Person-Location: _____/____ Via Telephone Conference

Individuals present at the Interactive Process Consultation: _____

Reason for Interactive Process Consultation: ____ Employee Request for accommodation ____Receipt of work restrictions ____Other (Please describe _____)

Date of accommodation request:_____

Date of work restrictions:_____

Describe the requested accommodation/work restrictions:
_____
_____
_____

Is the requested accommodation/work restrictions: _____Permanent _____Temporary

Name of Health Care Provider: _____

Describe the specific essential job function/s the employee may be unable to perform without an accommodation:
_____
_____
_____
_____

Are the above-described limitations the subject of a worker's compensation claim? (Employees with work related injuries may also be eligible for a reasonable accommodation independent of the worker's compensation process.) Yes____ No____

Accommodation/s considered: (List all accommodation/s considered and, if applicable reason for employee's rejection of an offered accommodation):
_____
_____
_____
_____

Alternative vacant positions considered: (List all alternative vacant positions offered and, if applicable reason for employee's rejection of an offered alternative vacant position):
_____
_____
_____
_____

Accommodation or alternative vacant position granted or denied: (Be as specific as possible, including describing specific accommodation granted, or alternative vacant position offered and accepted or reason for denial of accommodation):

_____
_____
_____
_____

Accommodation/alternative vacant position granted is: ___ Permanent ___ Temporary (Duration _____) Under Consideration_____

If leave has been granted as an accommodation or extended leave is granted: Date Leave Begins: _____ Anticipated Return to Work Date: _____ Date of Follow-up Appointment With Health Care Provider_____

Has the employee also requested leave pursuant Family and Medical Leave Act/California Family Rights Act, Pregnancy Disability Leave or other leave in connection with the above described work related injury? YES ____NO ____If yes, please specify what was requested and when: _____; **If** NO**- Eligible employees will be referred to the Company's Human Resources Department for further information.**

Summary of Interactive Process Dialogue:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Employee Comments:

_____
_____
_____
_____
_____
_____

(If more space is needed, please complete on an additional page and attach)

Date for follow-up Interactive Process: _____ or _____Alternatively, will follow-up when advised of a change in employee's status.

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I certify that I have a disability that requires reasonable accommodation, which I believe will be met by the accommodation(s) requested above, and that I attended an interactive process on the date indicated above to discuss the accommodation request.

_____ _____ _____
Employee Name **Signature** **Date**

****

This is to confirm my participation in the interactive process described above.

_____ _____ _____
HR Department Representative **Signature** **Date**

_____ _____ _____
HR Department Representative **Signature** **Date**