Employee Name _____

Microsoft Accommodation Request

This form must be completed by you and your health care provider and returned within 15 days of receipt prior to Microsoft's consideration of any accommodation request. Upon receipt of this completed form, your accommodation request will be reviewed by the company, and a determination will be made by Microsoft about reasonable accommodation. Microsoft evaluates accommodation requests relating to medical conditions on a case by case basis consistent with applicable law.

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 an individual or family member of the individual, except as specifically allowed by this law. 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 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.

Employee to complete the following section:

EMPLOYEE NO	EMPLOYEE NAME (Last, First, MI)	EMAIL NAME
HOME ADDRESS (MAILING)	STREET	
	CITY	STATE ZIP
	HOME PHONE NO ( )	WORK PHONE NO ( )

I request and authorize my health care provider listed above to release health care information and records to Microsoft Corporation and its designated agents, including external accommodation specialists, to enable Microsoft to determine whether and how my medical condition impacts my ability to perform my job and/or whether any accommodations are required. This authorization includes any information relating to HIV, sexually transmitted diseases, mental or psychiatric disorders, drug abuse or alcohol abuse which is relevant to the above purposes. I understand that state law may require that this authorization expire 90 days after I sign it but I agree to extend that time period if and as needed for the above purposes.

_____ _____

Employee Signature Date

Health care provide to complete the following section:

Instructions: Please answer, fully and completely, all applicable questions. If you cannot provide a definitive answer (for example, about duration of limitations or restrictions), your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can. Terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to enable us to evaluate your patient's request for reasonable accommodation and may require us to contact you for more information.

HEALTH CARE PROVIDER'S NAME		PROFESSIONAL SPECIALTY/TRAINING	
STREET ADDRESS			
CITY/STATE	ZIP	PHONE NUMBER	FAX NUMBER /EMAIL ADDRESS

In order for your patient to be considered for reasonable accommodations, PLEASE ANSWER ALL QUESTIONS COMPLETELY:

1. Does your patient have an impairment that substantially impacts his/her ability to perform any one or more of the essential functions of his/her job?
   ☐ Yes ☐ No
   If "yes" to Question #1, please identify the impairment(s) at issue.

2. If "yes" to Question #1, please list the specific function(s) you believe your patient is unable to perform:

3. Please list the limitation(s) and/or restrictions (if any) that you believe result in a need for accommodation and explain why you believe the restrictions or accommodations are medically necessary for the employee to perform his/her essential job functions.

4. Are limitations(s) and/or restriction(s) ☐ temporary ☐ permanent
   If temporary, what is the anticipated duration of the limitation(s) and restriction(s)?

5. What is the approximate date your patient's present impairment commenced?

Employee Name _____

6. If your patient is requesting time off work due to a chronic impairment that results in periods of incapacity, state the likely duration and frequency of episodes of incapacity.

7. If your patient is requesting time off work or a reduced workload in order to obtain treatment, provide an estimate of the probable number of and intervals between such treatments, actual or estimated dates of treatment (if known), and period required for recovery if any.

8. Describe any other relevant medical facts which support the patient's request for accommodation:

9. Please describe any suggested accommodations that will enable your patient to perform all of the required essential job functions. If remote work is recommended, please complete page 3 of this form.

10. Additional comments:

I hereby certify that the above statements, in my opinion, describe the patient's medical condition and impairment, if any, the estimated duration thereof, and that I am a _____ licensed to practice in the state of _____.
(type of provider)

Health Care Providers Signature Date

Completed form may be faxed to Microsoft Benefits at 425-707-2244

.

Employee Name _____

Remote Work Addendum Questionnaire:

With work from home requests, we need to explore how the onsite environment might first be accommodated to meet your patient's needs and facilitate onsite work. Please review and complete the following list of the most common workplace adjustments to assist our team in determining effective accommodations, as appropriate, that support the employee in performing their essential job functions. **This form must be completed, in full, in order to continue the accommodation process, with respect to work from home requests**. Address each item with a completed response, answering whether the following accommodation would enable your patient to perform all of their essential job functions. Note: It is important that you explain why an onsite accommodation would not be effective in your opinion.

1. Implementing flexible work hours and/or scheduled breaks
☐ Yes
☐ No - please provide explanation:

2. Assignment to a private office
☐ Yes
☐ No - please provide explanation:

3. Using Noise canceling headsets
☐ Yes
☐ No - please provide explanation:

4. Installing frosted windows on current office space
☐ Yes
☐ No - please provide explanation:

5. Having access to private room for periodic rest/nap/breaks throughout the day
☐ Yes
☐ No - please provide explanation:

6. Using specialized ergonomic equipment at a dedicated workspace
☐ Yes – please list below
☐ No - please provide explanation:

7. Installing cubicle dividers around workspace
☐ Yes
☐ No - please provide explanation:

8. Assignment to an office in a location that meets other specific criteria (eg.: away from foot traffic or mechanical room, back toward or away from others, near bathroom or outside window)
☐ Yes – please list others below
☐ No - please provide explanation:

9. Installation of specific lighting at workspace
☐ Yes
☐ No - please provide explanation:

10. Securing a designated parking spot for mobility issues
☐ Yes
☐ No - please provide explanation:

11. Use of other assistive technologies or services: (eg: transcribed meeting notes, job skills coaching, etc)
☐ Yes: please list others below
☐ No - please provide explanation:

12. If none of the above options would enable your patient to perform all of their required essential functions and remote work is still recommended, please indicate the number of days/week and expected duration:

Employee Name _____