RAE (ReasonableAccommodation in Employment)

PARC (Physician's Accommodations & Restrictions Certification)

Forms

Instructions for Cast MemberCompletion

NOTE: If this request is related to a COVID-19 issue, you only need to complete the RAE [Reasonable Accommodation in Employment] form. You will be contacted if additional medical documentation is needed.

The RAE [Reasonable Accommodation in Employment] form is two pages long and should be filled out only by you, the Cast Member. Don't forget to sign the form before submitting!
The PARC [Physician's Accommodations and Restrictions Certification] form is three pages long, of which the entire first page should be filled out by you, the Cast Member, before giving to your physician. Don't forget to sign the form before giving it to your physician!
The forms can be sent via fax, email, or mailed.
Once the information requested is received from both you and your physician, you will be contacted at the primary phone number provided by you, on the form labeled RAE, within 24 hours.
For questions about completing the forms, please email
WDPR.Leave.Administration.Team@disney.com or call the phone number provided on the form.

WALT DISNEY PARKS AND RESORTS – CAST MEMBER REASONABLE ACCOMMODATION IN EMPLOYMENT (RAE) FORM

Submit this form via FAX, Email or Mail to the appropriate location listed below:

For: Walt Disney World Employees
Health Services
P.O. Box 10000, Lake Buena Vista, FL 32830-1000
PHONE: (407) 828-8877 FAX: (407) 938-4105

For: Disneyland Resort Employees
Health Services
1313 S. Harbor Blvd., DL361D, Anaheim, CA 92803-3232
PHONE: (714) 781-7833 FAX: (714) 781-4249

DPECP.Medical.Accommodations@disney.com

It is the policy of Walt Disney Parks and Resorts U.S., Inc. (the "Company") to provide reasonable accommodations to employees with a disability, whether physical or mental. The purpose of this form is to facilitate the discussion between the Company and you about potential workplace accommodations that will allow you to perform all of the essential functions of your job. You should not complete and submit this form if you are not seeking a reasonable workplace accommodation for a disability. Please complete all sections below. Medical information and records will be maintained in a confidential manner. The information requested in this form is necessary for the Company to identify possible reasonable workplace accommodations for you.

Select one: ☐ Current Cast Member ☐ Rehire ☐ Incoming College/Int'l Program ☐ New Hire

Name__________________________ Cast Member ID #__________________

Mailing Address______________________ Primary Phone #__________________

______________________________ Secondary Phone #__________________

Email Address________________________ ☐ I agree to receive voicemails about possible workplace accommodations at the phone numbers listed above.

Work Location________________________ Supervisor Name __________________

Role_____________________________ Supervisor Phone # __________________

NOTE: If this request is related to a COVID-19 issue, you only need to complete the RAE [Reasonable Accommodation in Employment] form. You will be contacted if additional medical documentation is needed.

1. What is the medical condition or disability for which you are requesting an accommodation? *A request for workplace accommodations must be supported by the information requested in the Physician's Accommodations and Restrictions Certification (PARC) form which your physician or health care provider must complete and FAX or Email or mail to the appropriate Health Services location listed above.*

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2. How does this medical condition or disability interfere with your ability to perform your job duties? *Tell us how your medical condition or disability prevents you from performing the essential functions of your job or makes it difficult for you to perform these duties.*

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3. Are you currently receiving any workplace accommodations for your medical condition or disability? If yes, please describe. *Tell us about any changes your leader is already making for you at work because of your medical condition or disability, such as allowing you to wear a brace, allowing you to sit down when you are tired, or having others carry heavy items, etc.*

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4. What specific workplace accommodations do you believe will enable you to perform all of the essential functions of your job?

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_______________________________ _______________

Signature Date

____

Print Name

WALT DISNEY PARKS AND RESORTS – PHYSICIAN'S ACCOMMODATIONS AND RESTRICTIONS CERTIFICATION (PARC) FORM

Submit this form via FAX, Email or Mail to the appropriate location listed below:

For: Walt Disney World Employees
Health Services
P.O. Box 10000, Lake Buena Vista, FL 32830-1000
PHONE: (407) 828-8877 FAX: (407) 938-4105

For: Disneyland Resort Employees
Health Services
1313 S. Harbor Blvd., DL361D, Anaheim, CA 92803-3232
PHONE: (714) 781-7833 FAX: (714) 781-4249

DPECP.Medical.Accommodations@disney.com

To Be Completed By Patient

CAST MEMBER/PATIENT SECTION

Select one: ☐ Current Cast Member ☐ Rehire ☐ Incoming College/Int'l Program ☐ New Hire

Patient Name______________________________

Mailing Address______________________________

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Email Address______________________________

Cast Member ID #____________________

Primary Phone #____________________

Secondary Phone #____________________

☐ I agree to receive voicemails about possible workplace accommodations at the phone numbers listed above.

To Be Completed By Patient

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Dr.__________________________, my physician or health care provider, to provide the information requested in this PARC form to Walt Disney Parks and Resorts U.S., Inc. (the "Company") for the purpose of the Company's determining possible reasonable workplace accommodations for me. This authorization will expire one year from the date of my execution of this authorization. I understand I have the right to receive a copy of this authorization.

NOTE: This authorization does not limit the Company's access to medical information under the Florida's Workers' Compensation Act or any applicable law.

Cast Member Signature______________________________ **Date** __________________________

To Be Completed By Medical Provider

CERTIFICATION OF RESTRICTIONS/LIMITATIONS

NOTE: This section must be completed by a licensed health care provider with knowledge of the patient's medical or psychological condition(s). *Please answer all questions. The information requested in this form is necessary for the Company to identify possible reasonable workplace accommodations for your patient.*

1. Date of Last Evaluation: ______________________

2. Medical Condition(s) – *workplace restrictions requests must include supporting diagnosis information.*

Condition (Diagnosis)________________________Date of Onset________________Expected End Date_______________

Condition (Diagnosis)________________________Date of Onset________________Expected End Date_______________

Condition (Diagnosis)________________________Date of Onset________________Expected End Date_______________

For Pregnancy – What is the expected delivery date (EDD)? ______________________

3. Describe the physical limitations or restrictions:

☐ **Temporary** - Start Date______________End Date* _______________**If unknown, list the date of the next scheduled office visit.*

☐ **Permanent** - Start Date ______________

No ☐ lifting, ☐ pushing or ☐ pulling more than______lbs. with the_________________(*optional - list body part*)

No ☐ sitting more than_____minutes per hour

No ☐ standing or ☐ walking more than______minutes per hour

No ☐ kneeling more than_____times per hour

No ☐ squatting more than_____times per hour

No ☐ climbing more than_____steps per hour

☐ Medical equipment: ____________________________

☐ Other: ____

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Additional Restrictions Details (if needed):
Be as specific as possible and use direct, clear language without statements such as "avoid lifting too much," or "may stand as tolerated."

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4. If applicable, please enter the dates you determined the patient was unable to work for medical reasons.

First Date Out of Work_______________Last Date Out of Work________________Actual Return to Work Date ________________

5. Are you a licensed health care provider or psychological practitioner with expertise and direct knowledge about your patient's medical or psychological condition(s)? ☐ Yes ☐ No – *If "No", do not proceed in completing this form.*

6. Please explain why the requested restriction(s) is necessary for the condition(s) identified in question #2. *Please explain how each proposed restriction will enable your patient to perform the essential functions of his or her job.*

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To Be Completed by Medical Provider

CERTIFICATION OF RESTRICTIONS OF LIMITATIONS (continued)

7. Apart from the work restrictions identified in question 3 on page 2, are there any other reasonable workplace accommodations that you have identified that would enable your patient to perform all of the essential functions of his or her job?

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Health Care Provider Signature______________________________ **Date**______________________________

Print Name______________________________ **Medical Specialty**______________________________

Phone______________________________ **License # / State**____________________/__________

Address ____

Revised June 26,2020