

ATTORNEY CLIENT PRIVILEGED COMMUNICATION

INFORMATION QUESTIONNAIRE

**EMPLOYMENT DISCRIMINATION CLASS COMPLAINT AGAINST THE UNITED STATES POSTAL SERVICE
(WESTERN AREA)**

**JOHN A. CYNCAR V. JOHN E. POTTER, POSTMASTER GENERAL, U.S. POSTAL SERVICE
EEOC CASE NUMBER 320-A1-8380X**

Name: _____ Date: _____

Mailing Address: _____

Home Telephone: _____ Email Address: _____

Work Location/Installation: _____ Pay Location: _____

Craft (Clerk, Carrier, Mailhandler, Other): _____ Work Phone: _____

Length of Employment with USPS? _____

Disability means a mental or physical impairment that substantially limits one or more of your major life activities, or you have a record of such impairment, or you are regarded as having such impairments.

1. Do you have a physical or mental impairment? Yes/No (Circle One)

2. Do you have more than one physical or mental impairment? Yes/No (Circle One)

3. What is (are) the impairment(s)?

4. Do you have any physical certification or records reflecting your impairment(s)? If yes, please detail those records and/or provide copies of them.

5. Are you “regarded as” having such an impairment by the U.S. Postal Service? If yes, please state with full and complete detail that basis. To the extent you have supporting documentation, please provide it as well.

6. On a scale of 1-10, with 1 meaning "no limitation" and 10 meaning "maximum limitation", what major life activity does each impairment substantially limit?

Life Activity	1st Impairment	2nd Impairment	3rd Impairment
a. caring for oneself	_____	_____	_____
b. performing manual tasks	_____	_____	_____
c. walking	_____	_____	_____
d. seeing	_____	_____	_____
e. hearing	_____	_____	_____
f. sleeping	_____	_____	_____
g. speaking	_____	_____	_____
h. breathing	_____	_____	_____
i. learning	_____	_____	_____
j. working	_____	_____	_____
k. sitting	_____	_____	_____
l. standing	_____	_____	_____
m. lifting	_____	_____	_____
n. reaching	_____	_____	_____
o. thinking	_____	_____	_____
p. concentrating	_____	_____	_____
q. interacting with others	_____	_____	_____
r. enjoying leisure time activities	_____	_____	_____
s. reading	_____	_____	_____
t. driving	_____	_____	_____
u. writing	_____	_____	_____
v. sexual life	_____	_____	_____
w. reproduction (children)	_____	_____	_____
x. other (specify)	_____	_____	_____

7. Do you have a record of your impairments? Yes/No (Circle One)

8. How old is the record of impairment, that is, how long have you been seen by a doctor or been diagnosed for this impairment? (check one for each impairment)

<u>1st Impairment</u>	<u>2nd Impairment</u>	<u>3rd Impairment</u>
a. 0-1 year _____	a. 0-1 year _____	a. 0-1 year _____
b. 1-2 years _____	b. 1-2 years _____	b. 1-2 years _____
c. 2-5 years _____	c. 2-5 years _____	c. 2-5 years _____
d. Over 5 years _____	d. Over 5 years _____	d. Over 5 years _____

9. Do you take mitigating measures for this impairment(s)? Yes/No (Circle One)

Note: A mitigating measure can include the following: Medication, reasonable accommodation, exercise, therapy (physical & mental), auxiliary aids, etc. If a mitigating measure minimizes the effect of an impairment you may not meet the statutory definition of a disability. However, if a mitigating measure has side effects, minimal effects, or aggravates another impairment, you may meet the statutory definition of having a disability. If you choose not to utilize mitigating measures, you may not meet the statutory definition of having a disability.

10. What type of mitigating measure due you use?

- a. Prescription medication _____
- b. Reasonable accommodation _____
- c. Exercise (Monitored) _____
- d. Therapy (Physical or Mental) _____
- e. Auxiliary aids (Hearing, oxygen, etc.) _____
- f. Other (specify) _____

11. Do the mitigating measures control the impairment? (Check One below)

- a. all the time _____
- b. most of the time _____
- c. half the time _____
- d. some of the time _____
- e. not at all _____

12. Do the mitigating measures have a secondary or side effect? Yes/No (Circle One)

13. Is the side effect (check one)

- a. significant _____
- b. moderate _____
- c. minimal _____

14. Is the impairment consistent or chronic (episodic)? Consistent/chronic(episodic) (Circle One)

15. Was the impairment active during the alleged discriminatory period? Yes/No (Circle One)

16. If the impairment was active during the alleged discriminatory period, was it with or without mitigating measures? With/without (Circle One)
17. Have you ever asked for a "reasonable accommodation" for your impairment? Yes/No (Circle One) If yes, please state with full and complete detail the number of times you have asked for a "reasonable accommodation," who you asked and their response. Note: A request for reasonable accommodation can be something as simple as requesting sick leave for your impairment. You did not need to formally state that you requested a reasonable accommodation unless you submitted a formal request through channels or to a RAC (Reasonable Accommodation Committee).
18. Have you applied for FMLA leave between January 1, 1998 and December 31, 2002 for (any of) your impairment(s)? If yes, please specify the number of times you applied for FMLA leave and had that leave request denied. In the event you applied for leave outside these dates, please set forth in full and complete detail the timeframe within which you applied for FMLA leave and were denied. Note: If you have more than one denial, please use a separate sheet to answer the three questions below for each denial, and refer to that sheet below.
- a. When did you request leave for the FMLA covered condition?
 - b. Was your request approved? Yes/No (Circle One) If yes, how long was your leave?
 - c. Were you paid during this period? Yes/No (Circle One) If yes, by what means? (Sick leave, vacation, annual leave) If no, was that your election, or did your employer force the issue, and if so, what was the reason given for Leave With Out Pay (LWOP)?
 - d. If your request for leave was not approved, describe how your request for leave was treated.
 - e. Did USPS require a doctor's certification for your health condition:
 - I. When?
 - II. If more than once, on how many occasions, and when?
 - III. Did USPS require recertification or a second opinion?
 - IV. If yes, how often was recertification or other opinions required?
 - f. When you returned from leave, did you return to same or similar position? Please describe.

- g. Did you receive the same pay and benefits?
- h. Did you have the same or similar job duties and responsibilities? Please describe.
- i. Did you experience any different treatment upon your return from leave? Please describe.
- j.
 1. Did you suffer any economic loss as a result of your leave (i.e., termination, demotion, pay cut, or having to use sick leave, vacation, annual leave or LWOP (Leave Without Pay))? Describe each loss individually, including the estimated amount lost.
 2. Did you suffer any emotional distress (suffering) due to the denial of FMLA, and if so, did you seek professional treatment (counseling) from any professional source, to include EAP (Employee Assistance Program). If so, please describe the counseling you received and whether you were required to take any medication, or change medication, for this emotional distress.
- k. Did you file a grievance or internal complaint regarding the denial of leave or treatment you received concerning your request for FMLA leave?
 - I. If yes, when?
 - II. How was the grievance/complaint resolved?
- l. At any point in time during the relevant time period did you become afraid to, or hesitate to use FMLA leave based upon how you were treated?
- m. At any point in time, were you subject to disciplinary action for leave violations after your FMLA status was denied? If yes, please provide the dates of all disciplinary actions and the substance of such actions.

19. Below you will find items which you need to complete. In the "Date Denied" column, write in the actual date of the letter from the FMLA Coordinator, or your supervisor, whichever would apply. In the "Reason Given" column, write in, as briefly as possible, the reason given in the letter from the FMLA Coordinator, or your supervisor, whichever would be appropriate. In the last column, if it is the initial certification, or previous certification request, or if it is an initial recertification, or previous recertification request, please indicate so, and the date of such request if it was a previous (re)certification request.

Date Denied	Reason Given	Initial or Previous (Re)Certification
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
d. _____	_____	_____
e. _____	_____	_____
f. _____	_____	_____
g. _____	_____	_____

20. Did you initiate a grievance for any of the above violations? Yes/No (Circle One)

21. If so, for which items did you initiate a grievance (a-g, or all)?

22. Did you win the grievance(s)? Yes/No/Some (Circle One).

23. If you circled "yes", which grievances did you win (a-g, or all)? _____

24. Which grievances did you lose (a-g, or all)? _____

25. Did the grievance(s) set a precedent? Yes/No (Circle One)

26. If you circle "yes", which grievance was settled and what precedent did it set:

(Printed Name)

(Signature)

(Date)

PLEASE REMEMBER TO INCLUDE ANY DOCUMENTATION YOU MAY HAVE AND RETURN THE COMPLETED QUESTIONNAIRE TO:

Kathi Donahue, McNamara & Martinez LLP, 1640 E. 18th Avenue, Denver, Colorado 80218