



UNIVERSITY OF WASHINGTON
HEALTH CARE PROVIDER STATEMENT
 FOR DISABILITY ACCOMMODATION REQUESTS

THIS SECTION TO BE COMPLETED BY EMPLOYEE

RE: Name of UW Employee (Last)	(First)	(M.I.)	Department
Employee's Job Title	Work Email		Work Phone - -
Work Schedule (days/hours)			
Name of Health Care Provider	Patient No./Date of Birth		Health Care Provider's Phone - -

I hereby authorize the above-named health care provider to complete this form and disclose to the University of Washington and its authorized representatives the following information related to my health care: diagnosis of relevant conditions, treatment plan, my ability to perform my work, recommendations, history, reports and correspondence. I understand that it may be necessary for the University representatives to share this information for purposes related to accommodation of a disability. I authorize the University to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Once disclosed, the law does not always require the recipient of my information to maintain the confidentiality of my health care information. I understand that I have the following rights: a) to inspect or receive a copy of my protected health information, b) to receive a copy of this signed authorization, and c) to refuse to sign this authorization. I understand that information obtained under this release is a confidential medical record and is maintained separate from my personnel file. This authorization is valid for 90 days after the date of my signature below. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named health care provider will not condition treatment or payment based on receipt of this signed authorization.

- (Check one): I **do** authorize my health care provider to discuss directly with University representatives any medical information relevant to my request.
- I **do not** authorize my health care provider to discuss directly with University representatives any medical information relevant to my request. **NOTE:** If you check this box, processing may be delayed

By signing this page I acknowledge that I have read and agreed to the above terms.

Employee's Signature _____ Date _____

INSTRUCTIONS TO THE HEALTH CARE PROVIDER

Your patient is requesting an accommodation regarding her/his employment situation. The specific information you provide will assist us in determining appropriate services and/or accommodations, if any, for this employee. We encourage you to be thorough in your evaluation as you complete the attached sections.

NOTE: Failure to complete this form in a timely manner may lead to delay or denial of a requested accommodation for your patient.

Please complete Parts I, II, III and any other sections checked below.

- I. Evaluation Summary (Page 2)
- II. Signature of Health Care Provider (Page 2)
- III. Ability to Work Summary (Page 2)
- IV. Physical Capacities Evaluation (Page 3)
- V. Cognitive/Psychological Capacities Evaluation (Page 4)
- VI. Other Restrictions & Effects of Medication (Page 4)
- VII. Disability Parking/Transportation Evaluation (Page 5)

Please return form to:

DISABILITY SERVICES OFFICE
 4045 Brooklyn Avenue NE #230
 Seattle, WA 98105-6261

or

BOX 354560

FAX: 206-685-7264

(If the form is faxed, then follow up by sending the hardcopy by mail)

NOTE TO EMPLOYEE: Do not return this form to your department supervisor.

I. EVALUATION SUMMARY

Name of Patient (Last) (First) (M.I.)

Table with 4 columns: Statement of Pertinent Diagnosis(es) and Functional Limitation(s), SEVERITY (MILD, MODERATE, SEVERE), CONDITION (TEMPORARY, PERMANENT), and ONSET. Includes checkboxes for each category.

Cumulative Functional Limitations/Impact on work: (Select one) [] Mild [] Moderate [] Severe/Extreme [] Life-threatening

Select any that apply: [] Bed rest [] Hospitalization and/or surgery (Dates: mm / dd / yy to mm / dd / yy)

Is this condition the result of an on-the-job illness or injury? [] Yes [] No. If functional limitations are temporary, please indicate the expected duration: Until mm / dd / yy

II. SIGNATURE OF HEALTH CARE PROVIDER

The information provided herein is true and correct to the best of my knowledge.

Form fields for Name of Health Care Provider, Provider's Area of Specialty, Health Care Provider's Address (Street, City, State, ZIP), Signature of Health Care Provider, Phone No., Fax No., and Date.

III. ABILITY TO WORK SUMMARY

(Please check appropriate box). This determination is based on (select one): [] Written Job Analysis [] Written Job Description [] Job as described by the employee

A. (Choose only one of the following):

The employee/patient CAN... [] ...perform all of the duties of the CURRENT job. [] ...perform all of the duties of the CURRENT job with proposed modifications. [] ...return to the CURRENT job and perform all the duties after a medically necessary leave.

The employee/patient CANNOT... [] ...and will NOT be able to perform the essential duties of the CURRENT position even after a leave of up to 6 months and CANNOT work at least 50% time in another job. [] ...perform the essential duties of the CURRENT position within the next 6 months but CAN WORK AT LEAST 50% in ANOTHER job. State maximum percent time _____.

B. If Temporary or Permanent modification of job is recommended (e.g. work schedule, lifting, graduated return to work, etc.).(Please specify):

Is this modification medically necessary? [] Yes [] No Duration of proposed modification? _____

C. If a Medical Leave of absence is recommended: (Please specify): I anticipate leave to extend from mm/dd/yy to mm/dd/yy. Employee/patient will be able to return to work on mm/dd/yy.

V. COGNITIVE /PSYCHOLOGICAL CAPACITIES EVALUATION

Name of Patient (Last) (First) (M.I.)

Statement of psychological/cognitive diagnosis(es), (include the DSM-IV diagnosis):

How often is patient receiving treatment from you and/or another health care provider for this condition?

Health Care Provider: Please identify functional limitations of diagnosis(es):

Patient has the ability to meet the cognitive demands of the job as described in the cognitive job analysis or job description. (select one) Cognitive Job Analysis Job Description Job as described by employee Yes No

Patient has the ability to meet the psychological demands of the job as described by the cognitive job analysis or job description. (select one) Cognitive Job Analysis Job Description Job as described by employee Yes No

Patient has the ability to multitask without loss of efficiency or accuracy. This includes the ability to perform multiple duties from multiple sources. Yes No

Patient has ability to work and sustain attention with distractions and/or interruptions. Yes No

Patient is able to interact appropriately with a variety of individuals including customers/clients. Yes No

Patient is able to deal with people under adverse circumstances. Yes No

Patient has the ability to work as an integral part of a team. Includes ability to maintain workplace relationships. Yes No

Patient is able to maintain regular attendance and be punctual. Yes No

Patient is able to understand, remember and follow verbal and written instructions: Yes No
Simple instructions Yes No
Detailed instructions Yes No

Patient is able to complete assigned tasks with minimal or no supervision. Yes No

Patient is able to exercise independent judgment and make decisions. Yes No

Patient is able to perform under stress and/or in emergencies. Yes No

Patient is able to perform in situations requiring speed, deadlines, or productivity quotas. Yes No

Clarify or add any additional information here:

VI. OTHER RESTRICTIONS & EFFECTS OF MEDICATION

If there are other restrictions you have not described elsewhere, please describe here:

Are these restrictions medically necessary? Yes No Anticipated duration of these restrictions _____.

Is patient currently prescribed medication that would impair cognitive function, ability to operate machinery, stay alert, be punctual, or maintain regular attendance? Yes No

If Yes, please explain and include the anticipated duration that employee will be prescribed this (or similar) medication: