



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 BOX 354560 FAX: 206-685-7264
 4045 Brooklyn Avenue NE #230 *or* (If the form is faxed, then follow up
 Seattle, WA 98105-6261 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.)

Statement of Pertinent Diagnosis(es) and Functional Limitation(s): <i>(For each Pertinent Diagnosis(es), please describe Functional Limitation(s))</i>	SEVERITY			CONDITION		ONSET How long have you been treating employee for this condition?
	MILD	MODERATE	SEVERE	TEMPORARY	PERMANENT	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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: _____ to _____)*
(Date: mm / dd / yy) (Date: 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 _____
(Date: mm / dd / yy)

II. SIGNATURE OF HEALTH CARE PROVIDER

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


Name of Health Care Provider <i>(please print or type)</i>	Provider's Area of Specialty	If Board certified, indicate in which area	
Health Care Provider's Address (Street)	(City)	(State)	(ZIP)
Signature of Health Care Provider	Phone No. - -	Fax No. - -	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. *(Proceed to Section B.)*

...return to the **CURRENT** job and perform all the duties **after a medically necessary leave**. *(Proceed to Section C.)*

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**. *(Proceed to Section IV, page 3 and Section V, page 4, as appropriate.)*

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 _____ to _____. Employee/patient will be able to return to work on _____.
mm/dd/yy mm/dd/yy mm/dd/yy

VII. DISABILITY PARKING / TRANSPORTATION EVALUATION

Health Care Provider: If patient has requested either Disability Parking Permit, use of other transportation service or room relocation, please fill out the information listed below. Please also complete Section I Evaluation Summary and II Signature (page 2).

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

A. Patient can negotiate curbs
 Yes No

B. Patient is able to climb or descend stairs at the checked grades:

NO. OF STAIRS / GRADE	5%	10%	15%	20%
1 - 4				
5 - 10				
11 +				

C. Patient can transport himself/herself

1/2 block = 200'
 1 block = 400-500'
 3 football fields = 1083'

- less than 200 feet 600 feet to 800 feet
 200 feet to 400 feet 800 feet to 1000 feet
 400 feet to 600 feet Unrestricted

D. Patient uses

- wheelchair (*Check one*)
 manual wheelchair crutches
 motorized wheelchair
 has height of _____ inches while seated in wheelchair cane
 scooter other _____

E. Patient is

- blind or visually-impaired
 easily fatigued
 other _____

F. Does Patient have WA State disability permit?

- Yes No

Expiration Date: _____

Tag #: _____

Name of Health Care Provider (*please print or type*) _____

I verify that the information provided herein is true and correct to the best of my knowledge.

Signature of Health Care Provider _____ Date _____

THIS SECTION TO BE COMPLETED BY THE DISABILITY SERVICES OFFICE

Name of Employee _____ Department _____ Phone Number _____

Employee Work Location/Building _____ Referring Person _____ Phone Number _____

Disability is: Mo. Day Yr. <input type="checkbox"/> Temporary through: _____ <input type="checkbox"/> Permanent	Employee was referred to: <input type="checkbox"/> Parking Services <input type="checkbox"/> Property and Transport <input type="checkbox"/> Both	Does employee have WA State disability permit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date referred: Mo. Day Yr. _____
		Expiration Date _____ Tag # _____	