

HEALTH CARE PROVIDER STATEMENT

Disability Accommodation

EMPLOYEE COMPLETES THIS SECTION

Name (Last)	(First)	(M.I.)	Department
Employee's Job Title	Work Email		Work Phone - -
Work Schedule (days/hours)			
Name of Health Care Provider	Employee 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: the diagnosis(es) of relevant conditions, treatment plan(s), 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.

I hereby authorize my health care provider to discuss directly with University representatives any medical/mental health information relevant to my accommodation request.

By signing this page, I acknowledge that I have read and agree to the terms described above. (NOTE TO EMPLOYEE): If you do not provide authorization for your health care provider to discuss the medical/mental health information relevant to your accommodation request, processing of your accommodation request may be delayed.

Employee's Signature _____ Date _____

(To Employee: DO NOT RETURN THIS FORM TO YOUR DEPARTMENT SUPERVISOR)

Return all completed employee and health care provider portions of this form to the designated UW Human Resources office or the Disability Services Office.

DISABILITY SERVICES OFFICE Staff Human Resources Center 1320 NE Campus Parkway Box 354560 Seattle, Washington 98105	FAX: 206-685-7264 (if form is faxed, be sure to follow up by sending the hard copy by mail)
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HEALTH CARE PROVIDER COMPLETES THIS SECTION

Your patient is requesting an accommodation regarding her/his employment. The information you provide is critical to our ability to determine the appropriate services and/or accommodations, if any, for this employee. Please be thorough in your evaluation as you complete the attached sections as it will help us assist your patient. **Your timely completion of this form is essential to our ability to respond to your patient's accommodation request.**

Please complete Parts I, II, III and any additional sections checked below. If you fax the completed form, please send the original hard copy by mail to the address designated at the bottom of page one.

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

I. EVALUATION SUMMARY			
Pertinent Diagnosis(es)	Describe Related Functional Limitation(s):	Temp/Perm?	Onset: Duration of treatment for this condition?

Is this condition the result of an on-the-job illness or injury? Yes No

II. SIGNATURE OF HEALTH CARE PROVIDER			
Health Care Provider Name (please print or type)		Provider's Specialty: Please indicate any board certifications	
Health Care Provider's Address (Street)	City	State	ZIP
Health Care Provider Signature		Phone No.	Fax No.
Date		- -	- -

III. ABILITY TO WORK SUMMARY	
Please check appropriate box: My assessment is based on (select one): <input type="checkbox"/> Written Job Analysis; <input type="checkbox"/> Written Job Description; <input type="checkbox"/> Job as described by the employee	
A. Choose <u>only one</u> of the following:	
<input type="checkbox"/> The employee/patient CAN now perform all the duties of the CURRENT job: {IF CHECKED, STOP HERE, SIGN AND RETURN FORM} <input type="checkbox"/> The employee/patient CAN now perform all the duties of the CURRENT job with proposed modifications . (Complete Section B) <input type="checkbox"/> The employee/patient CAN return to this job after a medically necessary leave. (Complete Section C.), or	<input type="checkbox"/> The employee/patient CANNOT, and will not be able to perform the essential duties of the current position even after a leave of 6 months, and CANNOT work at least 50% time in another job : {IF CHECKED, STOP HERE, SIGN AND RETURN THE FORM} <input type="checkbox"/> The employee/patient will not be able to perform the essential duties of the current position within the next 6 months, but CAN now work at least 50% time in another job. State maximum percent time _____. (Go to Sect. IV, page 3 and Sect. V, page 4 (as appropriate)).
B. I recommend a <input type="checkbox"/> Temporary or <input type="checkbox"/> Permanent modification of the employee's job that I have determined to be medically necessary (e.g. work schedule, lifting, graduated return to work, etc.) Duration of proposed modification: from: (mm/dd/yy) _____ to: (mm/dd/yy) _____.	
C. I recommend a medical leave of absence from: (mm/dd/yy) _____ to: (mm/dd/yy) _____. Employee/patient will be able to return to work on: (mm/dd/yy) _____.	

IV. PHYSICAL CAPACITIES EVALUATION						
Patient Name	Last	First	MI			
IMPORTANT: Please complete the following items based on your clinical evaluation of the patient and other testing results. Any items that you do not believe you can answer should be marked "N/A". Please sign and date at Part II on page 2.						
A. In one shift, patient can (mark or check (✓) full capacity for each activity)						
	never	rarely Once a week or less	occasionally 0 – 2.5 hrs.	frequently 2.5 – 5.5 hrs.	continuously 5.5+ hrs.	
sit						
stand (in place)						
walk						
B. Patient can lift						
	never	rarely Once a week or less	occasionally 0 – 2.5 hrs.	frequently 2.5 – 5.5 hrs.	continuously 5.5+ hrs.	
0 to 10 lbs.						
11 to 25 lbs.						
26 to 50 lbs.						
51 to 100 lbs.						

C. Patient can carry

	never	rarely Once a week or less	occasionally 0 – 2.5 hrs.	frequently 2.5 – 5.5 hrs.	continuously 5.5+ hrs.
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					
51 to 100 lbs.					

D. Patient can push/pull (Pounds of Pressure)

	never	rarely Once a week or less	occasionally 0 – 2.5 hrs.	frequently 2.5 – 5.5 hrs.	continuously 5.5+ hrs.
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					
51 to 100 lbs.					

E. Patient is able to

	never	rarely Once a week or less	occasionally 0 – 2.5 hrs.	frequently 2.5 – 5.5 hrs.	continuously 5.5+ hrs.
Bend					
Squat					
Kneel					
Climb					
Reach out					
Reach above shoulder level					
Turn/twist (upper body)					

F. Patient is able to

	never	rarely Once a week or less	occasionally 0 – 2.5 hrs.	frequently 2.5 – 5.5 hrs.	continuously 5.5+ hrs.
Operate Heavy Machinery					
Drive a stick-shift vehicle					
Work with or near moving machinery					

G. Patient can use hands for repetitive action such as:

Not applicable to this patient

	Left		Right		TOTAL HOURS AT ONE TIME		TOTAL HOURS DURING ONE SHIFT	
	Yes	No	Yes	No	Left	Right	Left	Right
	Simple Grasping							
Pushing & Pulling								
Fine Manipulating								
Keyboarding or Typing								

VI. OTHER RESTRICTIONS & EFFECTS OF MEDICATION

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

Anticipated duration of these restrictions?

Are these restrictions medically necessary? Yes No

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

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

VII. DISABILITY PARKING / TRANSPORTATION EVALUATION

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

Patient Name Last First MI

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

½ 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 – manual or motorized (circle one) crutches
 scooter cane
 has height of _____ inches while seated in wheelchair other _____

E. Patient

is blind or visually-impaired
 fatigues easily
 other _____

F. Does Patient have WA State disability permit?

Yes; No;
 If yes 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.

Health Care Provider Signature

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: <input type="checkbox"/> Temporary through _____ Mo Day Yr <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 Expiration date _____ Tag # _____	Date referred: Mo. Day Yr.