



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:** Anne Marie Marshall, HR Specialist  
 UW Facilities Services – Box 352215  
 Seattle, WA 98195-2215  
 PHONE: (206) 221-4349  
 FAX: (206) 543-5135

*(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.) \_\_\_\_\_

Statement of <u>Pertinent Diagnosis(es)</u> and <u>Functional Limitation(s)</u> : <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

#### IV. PHYSICAL CAPACITIES EVALUATION

Name of Patient (Last)

(First)

(M.I.)

**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 my 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								

**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  NoPatient 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  NoPatient has the ability to multitask without loss of efficiency or accuracy. This includes the ability to perform multiple duties from multiple sources.  Yes  NoPatient has ability to work and sustain attention with distractions and/or interruptions.  Yes  NoPatient is able to interact appropriately with a variety of individuals including customers/clients.  Yes  NoPatient is able to deal with people under adverse circumstances.  Yes  NoPatient has the ability to work as an integral part of a team. Includes ability to maintain workplace relationships.  Yes  NoPatient is able to maintain regular attendance and be punctual.  Yes  NoPatient is able to understand, remember and follow verbal and written instructions:  Yes  No  
Simple instructions  Yes  No  
Detailed instructions  Yes  NoPatient is able to complete assigned tasks with minimal or no supervision.  Yes  NoPatient is able to exercise independent judgment and make decisions.  Yes  NoPatient is able to perform under stress and/or in emergencies.  Yes  NoPatient 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:

**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**

- 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

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

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