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 **206-685-7264 (fax) 206-543-6450 (v)** **4300 Roosevelt Way NE** **Roosevelt Commons West, 2nd Floor** **Box 354960** **Seattle, WA 98105-4960**	If form is faxed, please be sure to send a hard copy by mail, too.

(To HR: Check all parts to be completed by the Health Care Provider) HR Consultant:_____

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, lll 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.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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

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

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	Date	Phone No. - -
		Fax No. - -

ABILITY TO WORK SUMMARY

Please check appropriate box:

My assessment is based on *(select one)*: ☐ Written Job Analysis; ☐ Written Job Description; ☐ Job as described by the employee

A. Choose <u>only one</u> of the following:

☐ The employee/patient **CAN now** perform **all** the duties of the CURRENT job: {IF CHECKED, STOP HERE, SIGN AND RETURN FORM}

☐ The employee/patient **CAN now** perform all the duties of the CURRENT job **with proposed modifications**. (Complete Section B)

☐ The employee/patient **CAN** return to this job after a medically necessary leave. (Complete Section C.), or

☐ 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}

☐ 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 ☐Temporary or ☐ 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)_____

COGNITIVE/PSYCHOLOGICAL CAPACITIES EVALUATION

Patient Name Last First MI

Statement of psychological/cognitive diagnosis(es), *(Include the DSM-IVR 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:	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:

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, including the expected duration that employee will be prescribed this (or a similar) medication:

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
☐ 200 feet to 400 feet
☐ 400 feet to 600 feet
☐ 600 feet to 800 feet
☐ 800 feet to 1000 feet
☐ Unrestricted

D. Patient uses

☐ wheelchair – manual or motorized (circle one)
☐ scooter
☐ has height of _____inches while seated in wheelchair
☐ crutches
☐ cane
☐ 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)

_____

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:	Employee was referred to	Does employee have WA State disability permit?	Date referred:
☐ Temporary through Mo Day Yr. ☐ Permanent	☐ Parking Services ☐ Property and Transport ☐ Both	☐ Yes ☐ No Expiration date _____ Tag # _____	Mo. Day Yr.