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)_____

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	
	Left	Right	Left	Right				
	Yes	No	Yes	No				
Simple Grasping								
Pushing & Pulling								
Fine Manipulating								
Keyboarding or Typing								

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:

☐ Temporary through Mo Day Yr.
☐ Permanent

Employee was referred to

☐ Parking Services
☐ Property and Transport
☐ Both

Does employee have WA State disability permit? ☐ Yes ☐ No

Expiration date _____

Tag # _____

Date referred: Mo. Day Yr.