Office of Human Resources

Utica College / Department of Human Resources

Health Care Provider Statement/Appendix B

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	Health Care Provider's Phone Number	Employee/Patient DOB	

I hereby authorize the above named health care provider to complete this form and disclose to Utica College 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, medical history including but not limited to history of mental illness and treatments for drug and or alcohol abuse, reports and correspondence.

I understand that it may be necessary for Utica College representatives to share this information for purposes related to accommodation of a disability. I authorize the College 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 I have the following rights: a) to inspect or receive a copy of my health care 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.

I hereby authorize by healthcare provider to discuss directly with College 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. I further understand that not providing authorization for my health care provider to discuss the medical/mental health information relevant to my accommodation request may delay and/or impede processing of my accommodation request.

Employee Signature: _____ Date: _____

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

Return all completed employee health care provider portions of this form to the Office of Human Resources, Attention: Compensation & Benefits Manager

Mailing Address: Office of Human Resources Utica College 1600 Burrstone Road Utica, NY 13502	Fax: 315-792-3386 Phone: 315-792-3024	

Health Care Provider Completes This Section	
Your patient, (referenced on page 1), is requesting an accommodation regarding his/her employment. This 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 section 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 and 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.**	
☐ I. Evaluation Summary (Page 2)	☐ V. Cognitive/Psychological Capacities Evaluation (Page 4 -5)
☐ II. Health Care Provider Signature (Page 2)	☐ VI. Other Restrictions & Effects of Medication (page 6)
☐ III. Ability to Work Summary (Page 3)	
☐ IV. Physical Capacities Evaluation (Page 4)	

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

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 Date	Phone Number	Fax Number

III. ABILITY TO WORK
Please complete assessment based on Job Description/Analysis (attached)

A. Choose ONLY ONE of the following:

☐ The employee/patient CAN now perform all the duties of the CURRENT job [IF CHECKED, STOP HERE AND 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 CANNOT, and will not be able to perform the essential duties of the current position job [IF CHECKED, STOP HERE AND SIGN AND RETURN FORM]

☐ The employee/patient can return to this job after a medically necessary leave (Complete section C)

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, etc)

Duration of proposed modification from: (mm/dd/yyyy)_____to (mm/dd/yyyy)_____

C. I recommend a medical leave of absence from: (mm/dd/yyy)_____to (mm/dd/yyy)_____
Employee/patient will be able to return to work on: (mm/dd/yyyy) _____

IV. PHYSICAL CAPACITIES EVALUATION

Patient Name: 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 mark (X) to indicate your patient's level of capacity in each category.

A. In one shift, patient can (mark or check (x) full capacity for each activity)

	Never	Rarely (once a week or less)	Occasionally (0 – 2.5 hours)	Frequently (2.5 -5.5 hours)	Continuously (5.5 + hours)
SIT					
STAND (IN PLACE)					
WALK					

B. Patient can lift

	Never	Rarely (once a week or less)	Occasionally (0 – 2.5 hours)	Frequently (2.5 -5.5 hours)	Continuously (5.5 + hours)
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					

C. Patient can carry

	Never	Rarely (once a week or less)	Occasionally (0 – 2.5 hours)	Frequently (2.5 -5.5 hours)	Continuously (5.5 + hours)
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					

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

	Never	Rarely (once a week or less)	Occasionally (0 – 2.5 hours)	Frequently (2.5 -5.5 hours)	Continuously (5.5 + hours)
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					

E. Patient is able to

	Never	Rarely (once a week or less)	Occasionally (0 – 2.5 hours)	Frequently (2.5 -5.5 hours)	Continuously (5.5 + hours)
Bend					
Squat					
Kneel					
Climb					
Reach Out					
Reach Above					
Turn/Twist (upper body)					

F. Patient is able to

	Never	Rarely (once a week or less)	Occasionally (0 – 2.5 hours)	Frequently (2.5 -5.5 hours)	Continuously (5.5 + hours)
Operate Heavy Machinery					
Work with or near moving machinery					

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

					Total Hours During One Shift			
	Left		Right		Left		Right	
	Yes	No	Yes	No				
Simple Grasping								
Pushing and Pulling								
Fine Manipulation								
Keyboarding or Typing								

V. COGNITIVE/PSYCHOLOGICAL CAPACITIES EVALUATION

Patient Name: Last First M.I.

Statement of psychological/cognitive diagnosis((es). (Include the DSM – IV – TR diagnosis):

How often is patient receiving treatment form you and/or another health care provider for this condition?

Health care provider: Please identify limitations of diagnosis (es)

Patient has the ability to meet the cognitive demands of the job as described in the cognitive portion of the job description. ☐ 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 the 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 schedule and is punctual.	Yes No
Patient is able to understand, remember and follow verbal and written instructions Including simple and detailed instructions.	Yes No
Patient is able to complete assigned tasks with minimal or no supervision.	Yes No
Patient is able to exercise independent judgement 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 requirinf speed, deadlines, or productivity quotas.	Yes No

Clarify or add any additional information here:

VI. OTHER RESTRICTIONS & EFFECT 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 similar) medication:

Name of Employee	**Department**	**Phone Number**
Employee Work Location:		
Disability is: **Temporary through** ___/___/____ **Permanent**		
Accommodation decision:		
HR Representative Name:		