HUMAN RESOURCES
UNIVERSITY of WASHINGTON
Disability Services Office

Reset Form

Health Care Provider Statement (HCPS): Parking

Employee Form

1 Instructions

Return all completed employee and health care provider portions of this form to the Disability Services Office at 4320 Brooklyn Ave NE, Seattle, WA 98105-4960; (campus mail) Box 354960; (fax) 206-685-7264; (email) dso@uw.edu.

Do not return this form to your department.

2 Employee Information

1. Name (Last, First, MI):
2. Employee job title:
3. Work schedule (days/hours):
4. Name of Health Care Provider:

2.1 Employee Authorization

Please check each box and sign below.

☐ I 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 accommodation request: the diagnosis(es) of relevant conditions, treatment plan(s), my ability to perform my duties, recommendations, history, reports and correspondence.

☐ 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.

☐ 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 separately from my personnel file.

☐ I understand that this authorization is valid for 90 days after the date of my signature below.

☐ 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 understand that the above-named health care provider will not condition treatment or payment based on receipt of this signed authorization.

☐ By signing this page, I acknowledge that I have read and agree to the terms described above. I understand that if I do not provide authorization for my health care provider to discuss the medical/mental health information relevant to the accommodation request, processing the accommodation request may lengthen timeframes.

Employee Signature and date: _____

3 Health Care Provider Information

Your patient is requesting an employment accommodation. The information you provide is critical to our ability to determine the appropriate services and/or modifications, if any. Please be thorough in your evaluation and complete all relevant sections. Your timely completion of this form is essential to our ability to respond to our employee's accommodation request.

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.

3.1 Health Care Provider Contact

1. Provider Name (please print):
2. Provider Specialty:
3. Phone: Fax:
4. Provider signature and date:

4 Diagnosis/Cognizable Medical Condition Summary

Pertinent diagnosis(es)	Describe related functional limitations	Is the limitation permanent or temporary?	Date of onset and duration of condition

5 Parking/Transportation Evaluation

1. If the patient has a Washington state disability permit, respond to question A only. The patient must submit a copy of the wallet card ID to the Disability Services Office along with this form.

   A. Does the patient have a Washington state disability permit? ◯ Yes ◯ No

      a. Expiration date: _____ Tag#: _____

2. If the patient does not have a Washington state disability permit, complete the following:

   A. Can the patient navigate curbs? ◯ Yes ◯ No

   B. The patient can climb or descend stairs: ◯ Yes ◯ No

      a. If yes, how many stairs? _____

   C. The patient uses:

      ☐ Motorized wheelchair ☐ Manual wheelchair Height while seated in wheelchair: _____

      ☐ Scooter ☐ Crutches ☐ Cane

      ☐ Other. Please describe:

   D. The patient can transport themselves:

      ☐ Less than 200 feet (or a 1/2 block) ☐ 200 to 400 feet

      ☐ 400 to 600 feet ☐ 600 to 800 feet

      ☐ 800 to 1000 feet ☐ Unrestricted

   E. The patient is blind or visually impaired. ◯ Yes ◯ No

   F. Expected duration of the patient's need for parking or transportation assistance. _____

   G. Additional information:
