HUMAN RESOURCES
UNIVERSITY of WASHINGTON
Disability Services Office

Reset Form

Health Care Provider Statement (HCPS)

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 Physical Capabilities Evaluation

Please complete the following items based on your clinical evaluation of the patient and other testing results. Please mark "N/A" on any items that you cannot answer.

Activity	**Never**	**Seldom** 1–10% 0–1 hour	**Occasional** 11–33% 1–3 hours	**Frequent** 34–66% 3–6 hours	**Constant** 67–100% (Not restricted)
Sit					
Stand/walk					
Perform work from ladder					
Climb ladder					
Twist					
Bend/stoop					
Squat/kneel					
Crawl					
Reach: Left, Right, Both					
Work above the shoulders: L, R, B					
Keyboard: L, R, B					
Wrist (flexion/extension): L, R, B					
Grasp (forceful): L, R, B					
Fine manipulation: L, R, B					
Operate foot controls: L, R, B					
High impact vibratory tasks: L, R, B					
Low impact vibratory tasks: L, R, B					

Lifting/pushing	**Never**	**Seldom**	**Occasional**	**Frequent**	**Constant**
Lift: L, R, B					
Carry: L, R, B					
Push/pull: L, R, B					

6 Cognitive/Psychological Capacities Evaluation

1. Please identify functional limitations related to the medical condition without accommodation(s).

   A. The patient can ◯ _____ cannot ◯ _____ multitask/task switch without loss of efficiency or accuracy, including the ability to perform multiple duties from multiple sources.

   B. The patient can ◯ _____ cannot ◯ _____ work and sustain attention with distractions and/or interruptions.

   C. The patient can ◯ _____ cannot ◯ _____ interact appropriately with a variety of individuals including customers/clients.

   D. The patient can ◯ _____ cannot ◯ _____ deal with people under adverse circumstances.

   E. The patient can ◯ _____ cannot ◯ _____ work as an integral part of a team, including the ability to maintain workplace relationships.

   F. The patient can ◯ _____ cannot ◯ _____ maintain regular attendance and be punctual.

   G. The patient can ◯ _____ cannot ◯ _____ complete assigned tasks with minimal or no supervision.

   H. The patient can ◯ _____ cannot ◯ _____ exercise independent judgment and make decisions.

   I. The patient can ◯ _____ cannot ◯ _____ perform under stress and/or in emergencies.

   J. The patient can ◯ _____ cannot ◯ _____ perform in situations requiring speed, deadlines, or productivity quotas.

   K. The patient can ◯ _____ cannot ◯ _____ understand, remember and follow **simple** verbal _ _ and written instructions _____.

   L. The patient can ◯ _____ cannot ◯ _____ understand, remember and follow **detailed** verbal _ _ and written instructions _____.

   M. Is the employee currently prescribed medication that would impair their ability to operate machinery, be punctual or maintain regular attendance? ◯ Yes ◯ No

   If yes, please explain.

7 Ability to Work Summary

1. Please discuss job duties with your patient or review their job description to answer the following questions. Select only one of the following:

   ☐ The patient can now perform all the essential duties of their current job without restrictions. (If checked, sign, date and return the form.)

   ☐ The patient can now perform all the essential duties of their current job with proposed modifications. (If checked, complete section 7.2.B.)

   ☐ The patient can return to their job after a medically necessary leave of absence. (If checked, complete section 7.2.C.)

   ☐ The patient cannot perform the essential duties of their current position within the next 6 months from this date but can now regularly and reliably work _____FTE in another position. State maximum percentage time from 0–1.0, whereas .5 = 50% or 20 hours per week. (If checked, complete section 7.2)

   ☐ The patient cannot work in any capacity for the foreseeable future. (If checked, complete section 7.2.C)

2. I recommend:

   A. A permanent modification starting: _____

   B. A temporary modification starting: _____ ending: _____

   C. A leave of absence starting: _____ ending: _____

8 Medically Necessary Accommodations

An employee with a disability is entitled to accommodation only when it is needed because of the disability.

1. How does the patient's functional limitation(s) (identified in sections 4, 5, and/or 6) impact their ability to perform the essential duties of their position?

2. Which accommodation(s) would mitigate the patient's limitation(s) (stated in 8.1), and allow the patient to perform all the essential duties of their position?

3. Will the recommendations in 8.2 mitigate the work-related functional limitations stated in 8.1?
   ◯ Yes ◯ No
   Please explain.

9 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:
