UNIVERSITY OF WASHINGTON | Human Resources

HEALTH CARE PROVIDER STATEMENT

Disability Accommodation for UWF Employees Only

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.

	Partner Resources **Employee Relations Manager** **fsleave@uw.edu** **Box 354282** **Seattle, WA 98195-4282** **Fax: (206) 543-5135**	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, 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.

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 any FTE 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** regularly work _____FTE (state maximum percent time from 0 - 1.0 (.5 = 50% =20 hours per week)). Please complete page(s) 3 and/or 4 as appropriate for your patient.

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

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:

☐ 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.

Paid Family and Medical Leave

Statement of Employee Rights

You may qualify for Paid Family and Medical Leave
As of Jan. 1, 2020, Washington employees who have worked 820 hours or more in the qualifying period and experience (d) a qualifying event have access to Paid Family and Medical Leave.

Employees who have missed work due to family or medical reasons may be eligible for paid family or medical leave for the following qualifications:

- Care for and bond with a child younger than 18 following birth or placement
- Care for yourself or a family member experiencing a serious health condition
- Certain military-connected events.

Paid Family and Medical Leave requires that you give your employer(s) written notice at least 30 days in advance of when you plan to take leave. However, if the reason you need leave was not foreseeable, you may notify your employer(s) as soon as possible.

The Paid Family and Medical Leave Benefit Guide provides information on how to apply for benefits and submit weekly claims. It also explains your rights and responsibilities under the law. Download the guide at: www.paidleave.wa.gov/benefit-guide.

For more information about how to apply, contact us at 833-717-2273 or visit www.paidleave.wa.gov.

Important information for when you apply

- Employer UBI #: **178019988** (**91-1631806** for HMC employees)
- Employer offers supplemental benefits: Yes
  For more information about UW's supplemental benefits program visit the UW's How to file for PFML webpage for your employment program:
  - Staff and student employees: https://hr.uw.edu/ops/leaves/paid-family-and-medical-leave-pfml/how-to-file-for-pfml/
  - Faculty and other academic personnel: https://ap.washington.edu/ahr/policies/leaves/washington-state-paid-family-and-medical-leave-pfml/

Note: Except during the waiting week, employees cannot use employer provided paid time off at the same time as Paid Family and Medical Leave, unless the employer chooses to offer a "supplemental benefit." Supplemental benefits can be used along with Paid Family and Medical Leave to provide additional pay while an employee receives partial wage replacement through Paid Leave benefits. Employees may accept or reject supplemental benefit payments.

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

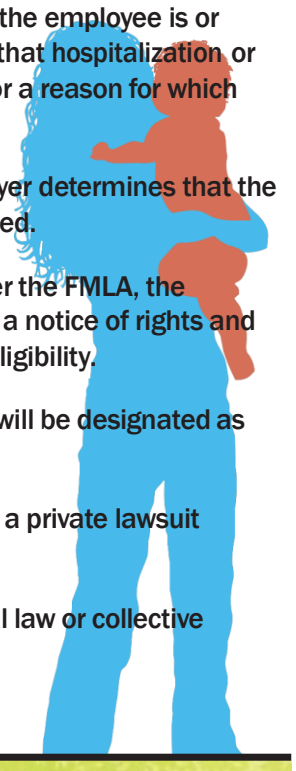
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16