HEALTH CARE PROVIDER STATEMENT
for Reasonable Accommodation Requests

HUMAN RESOURCE SERVICES
WASHINGTON STATE UNIVERSITY
FRENCH ADMINISTRATION 139
PULLMAN, WA 99164-1014

Refer to BPPM 60.21

INSTRUCTIONS TO THE HEALTH CARE PROVIDER

The patient named on the attached pages is requesting an accommodation. The information you provide assists Washington State University in determining appropriate services and/or accommodations for this employee/patient. Washington State University encourages you to be thorough in your evaluation as you complete the sections below. Attach additional information as needed.

NOTE: *Failure to complete this form in a timely manner may lead to delay or denial of a requested accommodation for this patient.*

Complete sections I, II, III and IV (required). Also complete any other applicable sections below.

- [X] I. Evaluation Summary (page 2 of 5)
- [X] II. Ability to Work Summary (page 2 of 5)
- [X] III. Signature of Health Care Provider (page 2 of 5)
- [X] IV. Physical Capacities Evaluation (page 3 of 5)
- [ ] V. Cognitive/Psychologicial Capacities Evaluation (page 4 of 5)
- [ ] VI. Other Restrictions and Effects of Medication (page 4 of 5)
- [ ] VII. Disability Parking/Transportation Evaluation (page 5 of 5)

RETURN FORM TO:

Human Resource Services
Washington State University
139 French Administration
Pullman, WA 99164-1014

OR

Human Resource Services
Washington State University
P.O. Box 641014
Pullman, WA 99164-1014

FAX 509-241-9090
(If the form is faxed, follow up by sending the signed paper copy by postal mail.)

NOTE TO EMPLOYEE: *Do **not** return this form to your department.*

HEALTH CARE PROVIDER STATEMENT (cont.)

EMPLOYEE/PATIENT NAME (Last, first, middle initial)	WSU ID NO.

I. EVALUATION SUMMARY

STATEMENT OF PERTINENT DIAGNOSIS(ES) AND FUNCTIONAL LIMITATION(S) (For each pertinent diagnosis(es), describe functional limitation(s).)	SEVERITY MILD	MODERATE	SEVERE	CONDITION TEMPORARY	PERMANENT	ONSET (How long have you been treating patient for this condition?)
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	

Cumulative functional limitations/impact on work: (Select one) ☐ Mild ☐ Moderate ☐ Severe/Extreme ☐ Life-threatening

Select any that apply: (Enter applicable dates.) ☐ Bedrest ☐ Hospitalization and/or surgery	From (mm/dd/yy)	To (mm/dd/yy)

Is this condition the result of an on-the-job illness or injury? ☐ Yes ☐ No	If functional limitations are temporary, indicate duration: (Include mm/dd/yy)

II. ABILITY TO WORK SUMMARY

DETERMINATION IS BASED ON: (Select one) ☐ Written job analysis ☐ Written job description ☐ Job as described by the employee

A. (Select **one only** of the following):

The employee/patient **can**:

☐ Perform **all** of the duties of the **current** job. (Proceed to Section III only (below).)

☐ Perform **all** of the duties of the **current** job with proposed modifications. (Proceed to Sections IIB and III only.)

☐ Return to the **current** job and perform all the duties **after a medically necessary leave**. (Proceed to Sections IIC and III only.)

The employee/patient **cannot**:

☐ And will **not** be able to perform the functions or essential duties of the **current** position even after a leave of up to six months and **cannot work at least 50 percent time** in another job. (Proceed to Section III only.)

☐ Perform the functions or essential duties of the **current** position within the next six months but **can work at least 50 percent time** in another job. (Indicate maximum percent time (below) and proceed to Sections III, IV, and V, as appropriate.)

Maximum percent time which employee is able to work

B. If recommending a **temporary or permanent job modification**, (e.g.,**frequency/duration of symptoms, limitations of condition, frequency/duration of limitations,** recommended modification(s), work schedule, lifting, graduated return to work, etc.), specify:

Is this modification medically necessary? ☐ Yes ☐ No	**Duration of proposed modification:** (**Include mm/dd/yy to mm/dd/yy)**

C. If recommending a **medical leave** of absence, specify:

Medical leave is anticipated to extend:	From (mm/dd/yy)	To (mm/dd/yy)	Date employee/patient will be able to return to work: (mm/dd/yy)

III. SIGNATURE OF HEALTH CARE PROVIDER

I certify that the information provided in this form (sections I, II, III, and as applicable, IV, V, VI, and VII) is true and correct to the best of my knowledge.

HEALTH CARE PROVIDER NAME (Print or type)	AREA OF SPECIALITY	IF BOARD CERTIFIED, INDICATE AREA	
HEALTH CARE PROVIDER ADDRESS	CITY	STATE	ZIPCODE

HEALTH CARE PROVIDER SIGNATURE	TELEPHONE	FAX	DATE

HEALTH CARE PROVIDER STATEMENT (cont.)

EMPLOYEE/PATIENT NAME (Last, first, middle initial)	WSU ID NO.

IV. PHYSICAL CAPACITIES EVALUATION

IMPORTANT: Complete the following items based on your clinical evaluation of the patient and other testing results. Enter "N/A" for any evaluation item that you do not believe you can answer.

A. IN ONE SHIFT, PATIENT CAN: (Mark or check employee/patient's full capacity for each activity.)

	Never	Rarely (Once a week or less)	Occasionally (0 - 2.5 hrs./day)	Frequently (2.5 - 5.5 hrs./day)	Continuously (5.5 hrs.+/day)
Sit					
Stand (in place)					
Walk					

B. PATIENT CAN LIFT: (Mark or check employee/patient's full capacity for each activity.)

	Never	Rarely (Once a week or less)	Occasionally (0 - 2.5 hrs./day)	Frequently (2.5 - 5.5 hrs./day)	Continuously (5.5 hrs.+/day)
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					
51 to 100 lbs.					

C. PATIENT CAN CARRY: (Mark or check employee/patient's full capacity for each activity.)

	Never	Rarely (Once a week or less)	Occasionally (0 - 2.5 hrs./day)	Frequently (2.5 - 5.5 hrs./day)	Continuously (5.5 hrs.+/day)
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					
51 to 100 lbs.					

D. PATIENT CAN PUSH/PULL (Pound of pressure): (Mark or check employee/patient's full capacity for each activity.)

	Never	Rarely (Once a week or less)	Occasionally (0 - 2.5 hrs./day)	Frequently (2.5 - 5.5 hrs./day)	Continuously (5.5 hrs.+/day)
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					
51 to 100 lbs.					

E. PATIENT IS ABLE TO: (Mark or check employee/patient's full capacity for each activity.)

	Never	Rarely (Once a week or less)	Occasionally (0 - 2.5 hrs./day)	Frequently (2.5 - 5.5 hrs./day)	Continuously (5.5 hrs.+/day)
Bend					
Squat					
Kneel					
Reach out					
Reach above shoulder level					
Turn/twist (upper body)					

F. PATIENT IS ABLE TO: (Mark or check employee/patient's full capacity for each activity.)

	Never	Rarely (Once a week or less)	Occasionally (0 - 2.5 hrs./day)	Frequently (2.5 - 5.5 hrs./day)	Continuously (5.5 hrs.+/day)
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 and pulling								
Fine manipulation								
Keyboarding or typing								

HEALTH CARE PROVIDER STATEMENT (cont.)

EMPLOYEE/PATIENT NAME (Last, first, middle initial)	WSU ID NO.

V. COGNITIVE/PSYCHOLOGICAL CAPACITIES EVALUATION

STATEMENT OF PSYCHOLOGICAL/COGNITIVE DIAGNOSIS(ES) (Include DSM-IV-TR diagnosis):

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

FUNCTIONAL LIMITATIONS OF DIAGNOSIS(ES): (Identify as indicated below.)

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 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 multitask without significant loss of efficiency or accuracy. This includes the ability to perform mutiple 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 challenging 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 meeting deadlines.	☐ Yes	☐ No
Patient is able to perform in situations requiring speed or productivity quotas.	☐ Yes	☐ No

Clarify or add any additional information:

VI. OTHER RESTRICTIONS AND EFFECTS OF MEDICATION

OTHER RESTRICTIONS NOT DESCRIBED IN OTHER SECTIONS OF THIS FORM: (Describe as needed.)

Are these restrictions medically necessary? ☐ Yes ☐ No	Anticipated duration of these restrictions:

MEDICATION: Is patient currently prescribed medication that may impair cognitive function, ability to operate machinery, stay alert, be punctual, or maintain regular attendance? ☐ Yes ☐ No
(If yes, explan below. Include the anticipated duration that this (or similar) medication will be prescribed for patient.)

HEALTH CARE PROVIDER STATEMENT (cont.)

EMPLOYEE/PATIENT NAME (Last, first, middle initial)	WSU ID NO.

VII. DISABILITY PARKING / TRANSPORTATION EVALUATION

If patient has requested either a disability parking permit, use of other transportation service, or a room relocation, provide the information indicated below.

A. PATIENT CAN NEGOTIATE CURBS: ☐ Yes ☐ No

B. PATIENT IS ABLE TO CLIMB OR DESCEND STAIRS AT THE INDICATED GRADES:

NO. OF STAIRS/GRADE	5%	10%	15%	20%
1-4				
5-10				
11+				

C. PATIENT CAN TRANSPORT HIMSELF OR HERSELF:

- ☐ Less than 200 feet
- ☐ 200 to 400 feet
- ☐ 400 to 600 feet
- ☐ 600 to 800 feet
- ☐ 800 to 1000 feet
- ☐ Unrestricted

D. PATIENT USES:

- ☐ Wheelchair (check one below; indicate seated height)
  - ☐ Manual wheelchair
  - ☐ Motorized wheelchair
- ☐ Scooter
- ☐ Crutches
- ☐ Cane
- ☐ Other (specify): _____

PATIENT HEIGHT WHILE SEATED IN WHEELCHAIR (Enter inches)

E. PATIENT IS:

- ☐ Blind or visually-impaired
- ☐ Easily fatigued
- ☐ Other (specify): _____

F. DOES PATIENT HAVE A WASHINGTON STATE DISABILITY PERMIT? (If yes, complete the fields at right.) ☐ Yes ☐ No	Expiration Date	Tag No.

THIS SECTION COMPLETED BY HUMAN RESOURCE SERVICES ONLY

EMPLOYEE NAME	DEPARTMENT	TELEPHONE
EMPLOYEE WORK LOCATION/BUILDING	REFERRING PERSON	TELEPHONE

DISABILITY IS:	EMPLOYEE REFERRED TO:	DOES EMPLOYEE HAVE WA STATE DISABILITY PERMIT?	DATE REFERRED:
☐ Temporary through: Mo. ____ Day ____ Yr. ____ ☐ Permanent	☐ Parking Services ☐ Other (specify:) _____	☐ Yes ☐ No Expiration Date: _____ Tag Number: _____	Mo. ____ Day ____ Yr. ____