HEALTH CARE PROVIDER STATEMENT

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 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 Blinn 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, history, reports and correspondence.

I understand that it may be necessary for the 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 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 abovenamed 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 Blinn's 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 Human Resources Office via fax to 979-209-7559.

HEALTH CARE PROVIDER COMPLETES THIS SECTION

Your patient is requesting a pregnancy 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 necessary.

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 only one 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 at least 50% time 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** work at least 50% time in another job. State maximum percent time_____. (Go to Sect. IV, page 3 and Sect. V, page 4 (as appropriate)).

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 puch/pull

	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 Detailed instructions	___ Yes ___ No ___ 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 ___600 feet to 800 feet
___200 feet to 400 feet ___800 feet to 1000 feet
___400 feet to 600 feet ___Unrestricted

D. Patient uses

___wheelchair – manual or motorized (circle one) ___crutches
___scooter ___cane
___has height of _____inches while seated in wheelchair ___other _____

E. Patient

___is blind or visually-impaired
___ fatigues easily
___other _____

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 HUMAN RESOURCES OFFICE

Name of Employee		Department	Phone Number
Employee Work Location/ Building		Referring Person	Phone Number
Disability is: ___ Temporary through (Date):_____ ___ Permanent	Employee was referred to ___ Parking Services ___ Property and Transport ___ Both	Does employee have TX State disability permit? ____Yes ____ No Expiration Date _____ Tag #_____	Date Referrred: