HEALTH CARE PROVIDER STATEMENT
Human Resources Disability Services
CWU EMPLOYEE

AUTHORIZATION FOR INFORMATION (Employee Completes this Section)

Applicant/Employee Name:		Employee ID#	
Employee's Job Title:		Date of Birth:	
Work Schedule:		Work Phone:	
		Work Email:	
Name of Health Care Provider:			
Provider's Phone#:			
Health Care Provider's Address:			

I hereby authorize the above-named health care provider to complete this form and disclose to Central Washington University 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. My health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) 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 a university representative 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/health care provider portions of this form to Central Washington University Human Resources office.

If this form is faxed, please be sure to send a hard copy by mail.	***Human Resources Partner, MS7425*** ***Central Washington University 400*** ***E University Way*** ***Ellensburg, WA 98926-7425*** ***Phone: (509) 963-1202*** ***Fax: (509) 963-1733***

HEALTH CARE PROVIDER COMPLETES THIS SECTION

Your patient is requesting an accommodation regarding his/her 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 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.**

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 family member receiving assistive reproductive services.

Please complete Parts I, II, III1 and any other attached sections, as checked below. If you fax the completed form, please send the original hard copy, and any attachments, by mail to the address designated at the bottom of page one.

☒ **I. Evaluation Summary (Page 2)**	☒ **III. Health Care Provider Signature (Page 2)**
☒ **II. Ability to Work Summary (Page 2)**	☐ **(Attached)**

I. EVALUATION SUMMARY

Pertinent Diagnosis(es):	Describe Related Functional Limitation(s):	Temp. Perm?	Onset; Duration of treatment?

Is this condition the result of an on-the-job illness or injury? ☐ Yes ☐ No

II. ABILITY TO WORK SUMMARY

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);
- ☐ 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 FORM); or
- ☐ The employee/patient **CANNOT, perform the essential duties of the current position** within the next 6 months, but **CAN now** work at least 50% time in another job. (Complete Section B).

B. I recommend ☐ Temporary or ☐ Permanent modification of the employee's job that I have determined to be medically necessary.

1. What limitation(s) is interfering with job performance, and how does it interfere with the employee's ability to perform the job functions?

2. What are your suggestions for possible accommodations to improve job performance?

3. How would the(se) accommodation(s) enable the employee to perform their job related tasks?

4. Are these accommodations medically necessary? ☐ Yes ☐ No
5. Duration of proposed modification: (MM/DD/YY) _____ to: (MM/DD/YY) _____

C. I recommend a medical leave of absence from: (MM/DD/YY) _____ to: _____
Employee/patient will be able to return to work on: (MM/DD/YY) _____

III. Signature of Health Care Provider

Health Care Provider Name (please print)	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. - -