Request for Accommodation Form

This is a confidential form to be completed by the employee and submitted directly to Human Resources:

Employee Name:___________________________

Job Title: _________________________________ **Department:**______________________

What is the accommodation you are requesting? Please be as specific as possible.

What limitation or condition is interfering with your ability to perform your job?

What job function or task are you having difficulty performing?

How will the requested accommodation assist you?

Please provide any other information you think would be helpful in evaluating your request.

I understand that all information obtained by my employer during this process will be maintained and used in compliance with ADA confidentiality requirements. I also understand that I may be required to provide my employer with medical documentation about my condition, its functional limitations, and appropriate accommodations.

______________________________ __________________

Employee Signature **Date**

PATIENT AUTHORIZATION FOR RELEASE
AND DISCLOSURE OF HEALTH CARE INFORMATION

Note to employee: *In order for us to obtain relevant medical information, your healthcare provider will require an authorization to release health information to us. You are not required to authorize the release of health information, but failure to provide authorization may mean that we cannot evaluate your request for an accommodation and/or medical leave.*

To Healthcare Providers and records custodian at ____________________________:
(Insert name of healthcare provider)

Pursuant to the Uniform Health Care Information Act, RCW 70.02 *et. seq*., as amended, the undersigned individual under your medical care hereby authorizes you to discuss and disclose the requested health care information as described below to:

Christine Beatty
PROVAIL
12550 Aurora Ave N, Seattle, WA 98133
Fax: 206-826-1171

Medical information requested: Any *medical information related to the employee's ability to perform the essential functions of their position, as outlined in the attached job description*.

I hereby authorize the above-named health care provider to complete the attached Medical Certification and disclose to PROVAIL and its authorized representatives the following information related to my health care, which may include diagnosis(es) of relevant conditions, treatment plan(s), ability to perform work, recommendations, history, reports, and correspondence.

I understand that I may revoke this authorization at any time by writing to the above-named provider, but I understand that cancellation will not affect any use of the information that was already released before the cancellation.

Authorization is valid for one hundred and twenty (120) days from the date of signature below.

____
Employee/patient Printed Name

____________________________ ________________
Employee/patient Signature **Date**

Medical Certification

Employee Name:__________________ Employee's Date of Birth:_______________

To Be Completed by Medical Provider:

1. Is the employee able to perform the essential functions of this position with or without reasonable accommodation?

Yes No

2. Does the employee suffer from a sensory, mental, or physical impairment?

Yes No

3. What is the impairment?

____

4. Does the impairment affect or substantially limit a major life activity?

Yes No

5. What is the expected duration of the impairment?

____

6. Please refer to the attached description of the employee's job. Please list any objective findings that require modifications or restrictions:

7. Estimated duration of work modification or restrictions.

____

8. Does the employee require medical leave? If so, how would this enable the employee to perform all of the functions of the job?

Complete the following if you recommend consecutive medical leave:

Duration: From [date] __________ to [date] __________

Complete the following if you recommend intermittent medical leave:

Increments: _____________________ [in hours/days]

Frequency: ____ times per week, or ____ times per month

10. Does the employee require a modified/reduced schedule? If so, how would this enable the employee to perform all of the functions of the job?

The employee's typical schedule is ____

Complete the following if you recommend a modified/reduced work schedule:

Duration: From [date] __________ to [date] __________

Weekly Schedule

Monday ______ a.m. to _____ p.m.
Tuesday ______ a.m. to _____ p.m.
Wednesday ______ a.m. to _____ p.m.
Thursday ______ a.m. to _____ p.m.
Friday ______ a.m. to _____ p.m.

11. Do you have any suggestions for possible accommodations that will enable the employee to perform the essential functions? Please describe:

Name of Health Care Provider: ____

Signature of Health Care Provider: ____

Date: _____________ Phone Number:_____________