Medical Certification (Completed by Healthcare Provider)

To the Healthcare Provider:

Your assistance is appreciated in providing information to assist in determining reasonable accommodation for the above-named individual, who identified himself/herself as your patient. The information you provide is critical to our ability to determine the appropriate services and/or accommodations, if any, for this person. 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 sections I - VII. If you fax the completed form, please send the original hard copy by mail to the address designated at the bottom of page one.

I. Evaluation Summary

**Please identify the requestor's physical or non-physical impairment(s):

Please describe the effects or limitations and expected duration (e.g., long-term, permanent, recent, temporary):

Please describe the effects or limitations of the impairment(s) with relation to the requestor's activities, if any:

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

II. Ability to Work Summary

Please check the appropriate box:

My assessment is based on *(select one)*: ☐ Written job/activity analysis ☐ Written job/activity description ☐ Job/activity as described by requestor

A. Choose **only one** of the following:

☐ The requestor/patient **CAN now** perform all the duties of the CURRENT job/activity without restriction (IF CHECKED, STOP HERE, SIGN AND RETURN FORM

☐ The requestor/patient **CAN now** perform all the duties of the CURRENT job/activity **with proposed accommodation(s).** (Complete Section B)

☐ The requestor/patient **CAN** return to the job/activity after a medically necessary leave. (Complete Section C), *or*

☐ The requestor/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

☐ The requestor **will not be able to perform the essential duties of the position within the next 6 months,** but **CAN now** work at least 50% time in another job with the following limitations:

State maximum percent time:

B. I recommend a ☐ **temporary or** ☐ **permanent** modification of the Requester's job/activity 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):

**A physical/non-physical impairment is one that substantially limits one or more major life activity.

III. Physical Capabilities Evaluation

Patient's Name

Last First MI

Please describe the effect or limitations of any physical impairment(s) which substantially limit(s) one or more major life activities and explain how such impairment(s) interfere(s) with the requester/patient's ability to perform essential job functions or enjoy equal benefits and privileges of employment if not accommodated (for non faculty requester/ patients, please review the attached information concerning the job duties:

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

You may, but are not required, to use Appendix A for assistance with your evaluation.

IV. Cognitive/Non-Physical Capacities Evaluation

Patient's Name

Last First MI

Please describe the effect or limitations of any non-physical impairment(s) which substantially limit(s) one or more major life activities and explain how such impairment(s) interfere(s) with the requester/patient's ability to perform essential job functions or enjoy equal benefits and privileges of employment if not accommodated (for non faculty requester/patients, please review the attached information concerning the job duties:

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

You may, but are not required, to use Appendix B for assistance with your evaluation.

V. Other Restrictions & Effects of Medication

If there are other restrictions you have not described, please describe here:

What is the anticipated duration of these restrictions?

Are these restrictions medically necessary? ☐ Yes ☐ No

Is the 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 similar) medication:

VI. Recommended Accommodations

Please offer any suggested accommodations **and** explain how each accommodation would enable the requester/ patient to perform essential job functions or enjoy equal benefits/privileges of employment:

If the requested accommodation is time taken off from work, how much is recommended?

Are there any activities or situations that should be avoided or that would present a significant risk of serious injury or death for the requestor?

VII. Signature of Healthcare Provider

Thank you for your assistance in providing this information so that we may assess the requester/patient's request. If you have any questions about this form, please contact the Office of Nondiscrimination & Accommodations Compliance at (407) 823-1336.

Healthcare Provider Name (please print or type)

Provider's Degree/Specialty: Please indicate any board certifications

License No.

Address (Street)

City

State

Zip Code

Healthcare Provider's Signature

Date

Phone Number

Fax Number

** **Please return all completed healthcare provider portions of this form to:**

Office of Nondiscrimination & Accommodations Compliance
University of Central Florida
12701 Scholarship Drive, Suite 101 (Building 81)
Orlando, Florida 32816-0030
Fax: (407) 882-9009 or Email: onac@ucf.edu

APPENDIX A

IMPORTANT: Please only complete the following items based on your clinical evaluation of the patient and other testing results. For any items that you do not believe you can answer, please select Not Applicable.

A. In one shift, patient can...

	Never	Rarely	Occasionally	Frequently	Not Applicable
Sit	◯	◯	◯	◯	◯
Stand (in place)	◯	◯	◯	◯	◯
Walk	◯	◯	◯	◯	◯

B. Patient can lift...

	Never	Rarely	Occasionally	Frequently	Not Applicable
0 to 10 lbs	◯	◯	◯	◯	◯
11 to 25 lbs	◯	◯	◯	◯	◯
26 to 50 lbs	◯	◯	◯	◯	◯
51 to 100 lbs	◯	◯	◯	◯	◯

C. Patient can carry...

	Never	Rarely	Occasionally	Frequently	Not Applicable
0 to 10 lbs	◯	◯	◯	◯	◯
11 to 25 lbs	◯	◯	◯	◯	◯
26 to 50 lbs	◯	◯	◯	◯	◯
51 to 100 lbs	◯	◯	◯	◯	◯

D. Patient can push/pull...

	Never	Rarely	Occasionally	Frequently	Not Applicable
0 to 10 lbs	◯	◯	◯	◯	◯
11 to 25 lbs	◯	◯	◯	◯	◯
26 to 50 lbs	◯	◯	◯	◯	◯
51 to 100 lbs	◯	◯	◯	◯	◯

E. Patient is able to...

	Never	Rarely	Occasionally	Frequently	Not Applicable
Bend	◯	◯	◯	◯	◯
Squat	◯	◯	◯	◯	◯
Kneel	◯	◯	◯	◯	◯
Climb	◯	◯	◯	◯	◯
Reach out	◯	◯	◯	◯	◯
Reach above shoulder level	◯	◯	◯	◯	◯
Twist/turn (upper body)	◯	◯	◯	◯	◯

F. Patient is able to...

	Never	Rarely	Occasionally	Frequently	Not Applicable
Operate heavy machinery	◯	◯	◯	◯	◯
Drive a stick shift vehicle	◯	◯	◯	◯	◯
Work with/near moving machinery	◯	◯	◯	◯	◯

G. Parient can use hands for repetitive action, such as:

Grasping	☐ Left hand	☐ Total hours at one time	☐ Total hours during one shift
	☐ Right hand	☐ Total hours at one time	☐ Total hours during one shift
Pushing & pulling	☐ Left hand	☐ Total hours at one time	☐ Total hours during one shift
	☐ Right hand	☐ Total hours at one time	☐ Total hours during one shift
Fine manipulating	☐ Left hand	☐ Total hours at one time	☐ Total hours during one shift
	☐ Right hand	☐ Total hours at one time	☐ Total hours during one shift
Keyboarding or typing	☐ Left hand	☐ Total hours at one time	☐ Total hours during one shift
	☐ Right hand	☐ Total hours at one time	☐ Total hours during one shift

APPENDIX B

IMPORTANT: Healthcare 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)* ☐ Yes ☐ No

☐ Cognitive Job Analysis ☐ Job Description ☐ Job as described by employee

Patient has the ability to meet the psychological demands of the job as described in the cognitive job analysis or job description. *(select one)* ☐ Yes ☐ No

☐ Cognitive Job Analysis ☐ Job Description ☐ Job as described by employee

Patient has the ability to multitask without loss of efficiency or accuracy. This includes 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 simple verbal and written instructions. ☐ Yes ☐ No

Patient is able to understand, remember and follow detailed verbal and written 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: