UNIVERSITY OF CENTRAL FLORIDA

Office of Institutional Equity

Formulario para Requerir una Acomodación Razonable – Profesional médico

Requestor Information- Información del Solicitante

ID: _____ Fecha Requerida: _____

Nombre: _____ _____ _____

Apellido *1er Nombre* *Inicial 2do Nombre*

Afiliación con UCF: _____

☐ Profesorado ☐ Personal ☐ Solicitante ☐ Otro _____

Teléfono Primario _____ Teléfono Alterno: _____

Email: _____ Título laboral: _____

College/División: _____ Departmento: _____

Coordinador/Supervisor: _____

Dirección del Campus : _____

Ley antidiscriminatoria sobre Información genética, *the Genetic Information Nondiscrimination Act of 2009 (GINA)* (siglas en inglés), prohíbe a los empleadores y otras entidades cubiertas por *GINA Title II*, de solicitar o requerir información genética de un individuo o de un miembro de familia del individuo, excepto que haya sido autorizado específicamente por esta ley. Para cumplir con esta ley, le pedimos que no provea ninguna información genética al responder a esta información médica. La información genética, *Genetic Information*, tal y como ha sido definida por *GINA* (siglas en inglés), incluye el historial médico familiar del individuo, los resultados de las pruebas genéticas de un individuo o miembro de la familia, el hecho de que un individuo o un miembro de la familia del individuo, buscó o recibió servicios genéticos, e información genética de un feto llevado por un individuo o miembro de la familia del individuo, o un embrión legalmente en manos de un individuo o un miembro de la familia recibiendo servicios de asistencia reproductiva.

1. Identifique los impedimentos físicos o no físicos, por los cuales Ud. se encuentra requiriendo acomodaciones, y la duración de tal impedimento. Incluya el diagnóstico más reciente.

Translated by Tania Gutierrez-Catasus, Certified Translator, 03/05/20

2. Explique cómo los impedimentos listados anteriormente, afectan su habilidad de desempeñar las funciones esenciales de su posición laboral o de gozar de los beneficios/privilegios de su empleo. Si Ud. es un empleado nuevo, indique las dificultades que Ud. anticipa para poder completar su trabajo, o de gozar de privilegios y beneficios laborales de forma equitativa. Sea lo más específico posible mencionando las asignaciones que Ud. considere difíciles de desempeñar.

3. Enumere las acomodaciones requeridas, las cuales le permitirán elaborar sus asignaciones, o gozar de los beneficios/privilegios laborales equitativamente. (Empleados no pertenecientes al profesorado: por favor adjunte su descripción de trabajo a la certificación de discapacidad del proveedor).

Si no se encuentra seguro del tipo de acomodaciones necesitadas, tiene Ud. alguna sugerencia que nosotros podamos explorar? ☐ Si ☐ No

Si la respuesta es Sí, por favor explique

¿Es su acomodación inmediata? ☐ Si ☐ No
Si la respuesta es Sí, por favor explique:

4. Por favor provéanos cualquier información adicional que nos pueda ayudar a procesar su pedido.

5. Verificación Médica de los Impedimentos (marque las cajitasapropiadas):

☐ He adjuntado los documentos médicos aplicables con este pedido.

☐ NO he adjuntado los documentos médicos aplicables con este pedido. Explique aquí debajo:

☐ ** Yo considero que ya he entregado suficiente información médica a:

_____ _____

(Nombre) (Titulo Laboral) (Contacto)

☐ La discapacidad y la necesidad de acomodación razonable es obvia y por tal razón no se necesita documentación médica. Explique aquí debajo.

**Por ejemplo: si Ud. ya ha requerido ausencia médica "FMLA" (siglas en inglés) por el mismo impedimento, el formulario llamado "Certification of Health Care Provider for employees of serious health conditions" podría ser suficiente.

Divulgación de Información: por el presente certifico que las declaraciones elaboradas anteriormente, son correctas y verdaderas, a mi saber y entender. Yo autorizo la divulgación de la información, arriba mencionada, a la Universidad de la Florida Central, con el propósito de determinar si yo cualifico para la discapacidad y pertinencia de este pedido de acomodación racional. Yo entiendo que es mi responsabilidad de completar el formulario de exoneración médica "Medical Release Statement" y de suministrar el formulario llamado "Provider Certification of Disability", si fuera requerido, al departamento de "EOAA" (siglas en inglés) de la Universidad de la Florida Central, para que mi pedido se evaluado. Además, autorizo a la Universidad de la Florida Central, de obtener clarificación de este documento y del formulario "Provider Certification of Disability", si fuera necesario, contactando a mi médico o proveedor médico(s).

_____

Firma del solicitante Fecha

**** Por favor envíe este formulario ya completado a:**
Office of Institutional Equity
University of Central Florida
12701 Scholarship Drive, Suite 101 (Building 81)
Orlando, Florida 32816-0030
Fax: (407) 882-9009 or Email: oie@ucf.edu

Translated by Tania Gutierrez-Catasus, Certified Translator, 03/05/20

UNIVERSITY OF CENTRAL FLORIDA

Office of Institutional Equity

Medical Information Request Form – Healthcare Provider
Formulario de Información Médica - Médico Proveedor

[redacted]

Nombre: _____ _____ _____
Apellido *1er Nombre* *Inicial 2do Nombre*

Afiliación con UCF: _____

☐ Profesorado ☐ Personal ☐ Solicitante ☐ Otro _____

Teléfono Primario _____ Teléfono Alterno: _____

Email: _____ Título laboral: _____

College/División: _____ Departmento: _____

Coordinador/Supervisor: _____

Dirección del Campus : _____

Yo, (Escriba su nombre en letra de molde)_____, Por la presente, autorizo al médico mencionado anteriormente, a que complete este formulario, y a divulgar la información relacionada con mi cuidado médico, tales como: el diagnóstico(s) o condiciones relevantes, planes de tratamiento(s), mi habilidad de desempeñar mis labores, recomendaciones, historial médico, reportes y correspondencia, con la Universidad de la Florida Central, y a sus representantes autorizados.

Yo entiendo que podría ser necesario, que los representantes de la Universidad, compartan esta información con el propósito de establecer acomodaciones por esta discapacidad. Yo autorizo a la universidad de compartir esta información con el personal y los representantes autorizados, en la medida necesaria, y para determinar si una acomodación es factible para el proceso de acomodación.

Esta autorización es válida por 90 días, después de la fecha en la que firmo este documento, en la parte inferior. Sin embargo, yo entiendo que puedo revocar este consentimiento, por escrito, en cualquier momento excepto al grado de acción ya tomada, basada en la autorización original. También entiendo, que el proveedor medico arriba mencionado, no determinará tratamiento o pagos basado en la recepción de esta autorización firmada.

_____ _____
Firma del Solicitante Fecha

NO ENTREGUE ESTE FORMULARIO AL SUPERVISOR DE SU DEPARTAMENTO

**** Por favor envíe todas las porciones, ya completadas de este formulario, pertenecientes al proveedor medico a:**

Office of Institutional Equity University of Central Florida
12701 Scholarship Drive, Suite 101 (Building 81)
Orlando, Florida 32816-0030
Fax: (407) 882-9009 or Email: oie@ucf.edu

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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 has 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 accommodationrequest.**

Please complete all sections checked below. 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**	☐ **V. Other Restrictions & Effects of Medication**
☐ **II. Ability to Work Summary**	☐ **VI. Recommended Accommodations**
☐ **III. Physical Capacities Evaluation** *(if applicable)*	☐ **VII. Signature of Health Care Provider**
☐ **IV. Cognitive/Psychological Capacities Evaluation** *(if applicable)*	☐ **Appendix A: Physical Capacities Evaluation Chart** ☐ **Appendix B: Cognitive Capacities Evaluation Chart**

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 illnessor injury? ☐ Yes ☐ No

II. Ability to Work Summary

Please check 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 this 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 THE FORM}

☐ The requestor/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 with the following limitations: _____
_____. State maximum percent time_____.

B. **I recommend a** ☐ **Temporary or** ☐ **Permanent** modification of the Requestor'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 absencefrom: (mm/dd/yy)_____to: (mm/dd/yy)_____.

Employee/patient will be able to return to workon: (mm/dd/yy)_____.

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

III. Physical Capacities Evaluation

Patient 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 requestor/patient's ability to perform essential job functions or enjoy equal benefits and privileges of employment if not accommodated (*for non-faculty requestor/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 the evaluation chart in Appendix A for assistance with your evaluation.

IV. Cognitive/Non-Physical Capacities Evaluation

Patient 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 requestor/patient's ability to perform essential job functions or enjoy equal benefits and privileges of employment if not accommodated (*for non-faculty requestor/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 the evaluation chart in Appendix B for assistance with your evaluation.

V. Other Restrictions & Effects of Medication

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

What is the 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 similar) medication:

VI. Recommended Accommodations

Please offer any suggested accommodations **and** explain how each accommodation would enable the requestor/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 requestor/patient's request. If you have any questions about this form, please contact the Office of Institutional Equity 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
_____ Healthcare Provider's Signature		Date	Phone No.	Fax No.

**** Please return all completed healthcare provider portions of this form to:**
Office of Institutional Equity
University of Central Florida
12701 Scholarship Drive, Suite 101 (Building 81)
Orlando, Florida 32816-0030
Fax: (407) 882-9009 or Email: oie@ucf.edu

APPENDIX A

IMPORTANT: Please only 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".

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 push/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								

Clarify or add any additional information here:

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 cognitivejob 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 thecognitive 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 distractionsand/or interruptions.	☐ Yes ☐ No
Patient is able to interact appropriately with a variety of individualsincluding 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 tomaintain 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:	