MOREHOUSE SCHOOL OF MEDICINE

Office of Disability Services

DISABILITY ACCOMMODATION REQUEST FORM

Employee/Applicant Information

Employee ID/Name: **Contact Number:**

Position Title: **Dept. ID/Name:**

Immediate Supervisor: **Contact Number:**

Department Head: **Contact Number:**

Accommodation Information

1. Please identify the limitation(s)/impairment(s) that you believe are affecting your ability to perform your job duties or, to participate in the application and selection process. Please include the expected duration of the limitation(s) or impairment(s.) It is not necessary to indicate a medical diagnosis or condition.

2. Please describe the accommodation(s) you are requesting, as well as any alternative accommodations, and how long you believe you will need the accommodation.

3. Explain how the requested accommodation(s) will allow you to perform the essential functions of your job, or will allow you to participate in the application and selection process:

4. Are there any essential functions of the job that you will be unable to perform, or aspects of the selection process you will be unable to complete, with or without the requested accommodation(s)? Please explain.

_____

_____

5. Has a physician, vocational rehabilitation specialist, or other health professional recommended a specific accommodation? Yes _____ No _____

   If yes, please attach a copy of their recommendations.

Note: An individual's need for accommodation or a particular may change over time as a result of changes in the individual's impairment, changes in the nature of the job, or changes in work location. What qualifies as reasonable in one set of circumstances may not qualify as reasonable in another. If and when circumstances change, it is your responsibility to notify this office if you need, or continue to need, a reasonable accommodation.

Acknowledgement

I give Morehouse School of Medicine's Office of Disability Services permission to explore coverage and reasonable accommodations, if any, under the Americans with Disabilities Act. This may include speaking to appropriate School personnel and/or my health care professional. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that I will be required to provide appropriate documentation of my impairment, including the impact of the functional limitations on my ability to perform the essential functions of my job.

I understand that it will be my responsibility to complete a medical release authorization and to provide a medical certification, if required, to the MSM Office of Disability Services for my request to be evaluated. I further understand that the MSM Office of Disability Services will evaluate and respond to me based upon the information that I provide. The information provided by me is true and correct to the best of my knowledge.

Employee/Applicant Signature: _____ Date: _____

Morehouse School of Medicine | Office of Disability Services

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 the Morehouse School of Medicine 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 School representatives to share this information for purposes related to my request for accommodation of a physical or psychological impairment. I authorize the School to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the process for evaluating my accommodation request. 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 as long as my request is being processed or for as long as I may be receiving an accommodation, whichever is longer. 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 on receipt of this signed authorization.

I hereby authorize my health care provider to discuss directly with School 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 MSM's Office of Disability Services.

MSM OFFICE OF DISABILITY SERVICES
720 Westview Drive, S.W., NCPC Room 408
Atlanta, GA 30310

	FAX: 404-752-1639 **(If form is faxed, be sure to follow up by sending the hard copy by mail)**

HEALTH CARE PROVIDER COMPLETES THIS SECTION

Your patient is requesting an 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 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 (Page 2)**	☒ **V. Cognitive/Psychological Capacities Evaluation (Page 4)**
☒ **II. Health Care Provider Signature (Page 2)**	☒ **VI. Other Restrictions & Effects of Medication (Page 5)**
☒ **III. Ability to Work Summary (Page 2)**	☐ **VII. Disability Parking/Transportation Evaluation (Page 5)**
☐ **IV. Physical Capacities Evaluation (Page 3)**	

I. 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

II. 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. - -

III. 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); or

☐ The employee/patient **CAN now** perform all the duties of the CURRENT job **with proposed modifications**. (Complete Section B); or

☐ 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.**; or

☐ 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) _____

IV. 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 push/pull (Pounds of Pressure)

	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 hand for repetitive action such as:

☐ Not applicable to this patient

	Left		Right		TOTAL HOURS AT ONE TIME		TOTAL HOURS DURING ONE SHIFT	
					Left	Right	Left	Right
Single Grasping								
Pushing & Pulling								
Fine Manipulating								
Keyboarding or Typing								

V. 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 multitask without loss of efficiency or accuracy. This includes the ability to perform multiple duties from multiple sources.	☐ Yes	☐ No
Patient has the ability to work and sustain attention with distractions and/or interruptions	☐ Yes	☐ No
Patient has the ability 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 ☐ Yes	☐ No ☐ 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:

VI. 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, include the expected duration that employee will be prescribed this (or a similar) medication:

VII. 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 _____

F Have you completed affidavit for Patient to receive GA State disability parking permit? ☐ Yes ☐ No

If yes, for what period of time _____

Name of Health Care Provider (please print or type)

I verify that the information provided herein is true and correct to the best of my knowledge.

Health Care Provider Signature Date

MOREHOUSE SCHOOL OF MEDICINE

OFFICE OF DISABILITY SERVICES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Subject: Authorization to release health information for ADA reasonable accommodation.

I hereby request and authorize:

_____
(Name of professional or institution)

_____ _____ _____ _____
(Street) (City) (State) (Zip)

to release my personal health information to the Office of Disability Services, Morehouse School of Medicine, 720 Westview Drive, SW, Atlanta, Georgia, 30310-1495, for the purpose of providing information as to my physical ☐ or mental ☐ capacity to perform the essential job functions of _____ . (Position Title)

I am engaged in the interactive process as required by the Americans with Disabilities Act (ADA) with the Office of Disability Services, Morehouse School of Medicine to explore reasonable accommodation alternatives that will allow me to work at Morehouse School of Medicine.

_____ is authorized to review the job description and provide
(Physician Name)
complete answers to the questions on the provided form and will return the form to the employer when completed. _____ is also authorized to orally
(Physician Name)
discuss my physical or mental capacity to perform work duties over the phone with the Office of Disability Services, Morehouse School of Medicine.

This authorization expires upon termination of my employment with Morehouse School of Medicine, or when I request in writing that it be withdrawn. I acknowledge that I have received a written copy of this authorization. I understand all of the notices set forth below.

_____ _____
(Employee Name) (Date)

_____
(Employee Signature)

Patient's Personal Representative's Section (if applicable):
I, _____, hereby certify that I am the personal representative of _____ and warrant that I have the authority to sign this form on the basis of:

_____ _____
(Personal Representative's Signature) (Date)

MOREHOUSE
SCHOOL OF MEDICINE

Important Notices under HIPAA

I, _____ understand that I may revoke this authorization at any time by
(Employee's Name)
providing the Office of Disability Services, Morehouse School of Medicine, Atlanta, Georgia with written notice that I am revoking this authorization. I understand, however, that I may not revoke any action that Morehouse School of Medicine has taken in reliance upon this authorization prior to the date I revoke this authorization. I also understand that the federal Americans with Disabilities Act (ADA) requires me to be an active participant in the interactive process and to provide Morehouse School of Medicine with my medical information that is necessary to determine what reasonable accommodation is appropriate for me. If I fail to cooperate in the interactive process or fail to provide the necessary medical information, I understand that the Office of Disability Services at Morehouse School of Medicine will not recommend accommodation.

I understand that this written authorization and the medical certification form completed by me will become an employment record and will be retained by Morehouse School of Medicine for six years as required by law. (45 CFR §§ 164.508 (b) and (c) and 164.530 (j). I understand that the federal Health Insurance Portability and Accountability Act (HIPAA) protected health information rules do not apply to an employment record and the Office of Disability Services may disclose the information to others with a business need to know for the purpose of evaluating the alternatives and implementing appropriate reasonable accommodation. Morehouse School of Medicine however will comply with the confidentiality rules required by the ADA.

I acknowledge that I have read and understand these notices.

_____ _____

(Employee Signature) (Date)

_____

(Witness Signature)

Patient's Personal Representative's Section (if applicable):

I, _____, hereby certify that I am the personal representative of _____ and warrant that I have the authority to sign this form on the basis of:

_____ _____

(Personal Representative's Signature) (Date)