Stanford HEALTH CARE
STANFORD MEDICINE

Directions: Employees must complete and return completed form to the Absence Management Team.
Confidential Fax #: 1-650-618-2243 / Email: HRAM@stanfordhealthcare.org

Disability Accommodation Letter to Healthcare Provider

Today's Date: _____ _____

Employee Name: _____

Employee current position: _____

Healthcare Provider Name: _____

Healthcare Provider Address: _____

Healthcare Provider Phone Number: _____

1. Please certify whether the above named patient has a bona fide disability (A physical or mental impairment which limits one or more of his/her major life activities): Yes ☐ / No ☐

2. Describe the nature and severity of the impairment. Include how the impairment(s) is interfering with performing the material conditions of their job:_____

_____

Employee <u>can safely perform these functions</u>: (*please check below*)

Lift /Carry	No restriction	Up to 5 lbs	10 lbs	25 lbs	50 lbs	Not at all	
Push /Pull	No restriction	Up to 5 lbs	10 lbs	25 lbs	50 lbs	Not at all	
Stand/walk			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Stoop/Bend at Waist			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Kneel/Squat			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Climb			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all

Sit			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Other (please describe)			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Work or Reach Above Shoulder with Left Arm / Right Arm *(Circle one or both.*)			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Repetitive use of Left Hand / Right Hand *(Circle one or both.*)			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Keyboard/mouse Left hand/ right hand *(Circle one or both.*)			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Working around equipment or machinery?			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc?			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Use of special visual or auditory protective equipment?			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Exposure to dust, gas, fumes or chemicals?			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Drive (To work / While at work) *(Circle one or both.*)			No restriction	Occasionally Up to 3 Hours	Frequently 3-6 Hours	Constantly 6 – 8+ Hours	Not at all
Number of hours patient may work each day:		☐ 4 hours ☐ 6 hours ☐ 8 hours ☐ 10 hours ☐ 12 hours					

3. Please list any additional work limitations/restrictions for patient's medical condition:

_____

_____

A. Please select one below and provide required dates:

☐ These limitations/restrictions are temporary and anticipated to start on _____ (date) and end on _____ (date).

☐ These are permanent limitations/restrictions starting _____ (date).

4. If, in your opinion, the only viable accommodation is time off work, please select one option below and provide required dates:
   - ☐ This patient should be off work starting _____ (date) and ending _____ (date).
   - ☐ This patient should be permanently off work starting _____(date).

5. If this is a modification to the original expected return to work date, please describe the medical facts that have changed: _____

   _____

6. Please provide a **definitive date** of when do you anticipate that employee will be able to return to regular work _____.

7. Would patient be able to return to work earlier if particular accommodation(s) provided? Yes ☐ /No ☐
   If yes, what is the recommended accommodation? _____

   _____

Date of patient's most recent medical visit _____

Date of next medical visit _____

_____ _____
Physician's/Provider's Signature Date

_____
Medical Specialty/Practice