Utah County Government Office of Human Resource Management

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General Guidelines for Documenting Physical Disability

The following guidelines are intended to assist the employee and the evaluator in completing the request for accommodations at Utah County Government.

A licensed health care provider with expertise in diagnosing and treating the employee's physical disability must document the disability by completing the attached forms. The employee's name must be clearly indicated on all documents submitted by the employee and by the health care provider. It is the employee's responsibility to collect the required forms and medical documentation from the health care provider and return them to the Office of Human Resource Management. The evaluation forming the basis for the request for accommodations must have been conducted within the last five years. The diagnostician/evaluator must have comprehensive training and direct experience working in the field (such as board certification by a recognized board.) In completing the required form(s), the evaluator must describe each of the following:

1. The academic credentials and qualifications that allow the evaluator to diagnose the disability and recommend accommodations.
2. The employee's impairment, including
    a. Diagnosis;
    b. History;
    c. Treatment, including medication, and the effect of treatment on the condition.
3. Documentation substantiating the disability, including an objective assessment to rule out the likelihood of malingering or the exaggeration of symptoms;
4. The physical/mental limitations currently experienced as a result of the impairment;
5. How long the limitations are expected to last:
6. How the physical/mental impairment impacts the specific tasks required by the job; and
7. How the accommodation being requested will reduce the impact of the documented functional limitation your disability imposes.

A general description of typical symptoms found in people with the employee's condition is not sufficient, nor are chart notes copied from the medical record without the analysis described above. Requests for accommodations must reference test results or clinical observations that support the need for the accommodation. It is important to understand that the mere documentation of the presence of a disability does not entitle the employee to accommodations(s). Rather, the impact of the disability on the employee's ability to perform essential job functions must be quantifiably and objectively documented so that reasonable accommodations can be determined. For example, if an employee with arthritis is seeking an accommodation due to slow typing speed, simply providing documentation to prove that the employee has arthritis is not sufficient; an objective test must be conducted that measures the employee's typing ability against the general population so the appropriate accommodation can be granted.

The diagnostician must include a detailed explanation as to why each SPECIFIC recommended accommodation is necessary and a detailed rationale for each accommodation requested. Requests for accommodations must reference test results or clinical observations that support the need for accommodation. Recommendations that are clearly excessive will bring the expertise of the evaluator into question.

You must return the following forms in order to be considered for an accommodation:

☐ **Medical/Healthcare Information Release**

☐ **Accommodation Eligibility Questionnaire**

☐ **Medical Disability Verification Form**

Medical/Healthcare Information Release

To be signed by Employee

A copy of this signed form must be provided to each diagnostician/evaluator.

I,_____, hereby authorize the professionals and/or facilities listed below to furnish and discuss with Utah County Government agents or representatives any information in his/her/its possession relevant to my request for accommodation of duties in my capacity as an employee of Utah County Government.

A complete photocopy of this authorization shall be accepted as if it were a signed original and is valid from the date of this release until such time as Utah County Government completes its evaluation of my application for accommodation. I release below named treatment professional/facility and Utah County Government and its agents and representatives from any liability associated with the disclosure of confidential or privileged medical/healthcare information.

Names, addresses, and phone numbers of professionals/facilities:

Name of professional:
Name of facility:
Address:
Phone number:

Name of professional:
Name of facility:
Address:
Phone number:

Name of professional:
Name of facility:
Address:
Phone number:

Name of professional:
Name of facility:
Address:
Phone number:

By signing this release, I represent that I have read the information, understand it, and agree with the authorization I now make.

_____ _____

(Signature) (Date)

Accommodations Eligibility Questionnaire
(see General Guidelines for more information)

Name of Employee:_____

1. Disability Status *(please check all that apply):*

    a. Do you have a:
    - ☐ Physical Disability?
        *Please specify*_____
    - ☐ Learning Disability?
        *Please specify*_____
    - ☐ Psychological Disability?
        *Please specify*_____

    b. How long have you had your disability?
    - ☐ 1 year
    - ☐ 2-5 years
    - ☐ 5-10 years
    - ☐ More than 10 years
    - ☐ Most of my life

    c. When was your disability diagnosed?
    - ☐ 1 year
    - ☐ 2-5 years
    - ☐ 5-10 years
    - ☐ More than 10 years

    d. Are you currently being treated?
    - ☐ Yes
    - ☐ No
        *Please explain*_____

    If yes:
    Provide the name and address of your treating professional(s):

Name of professional:
Name of facility:
Address:

List the treatment and/or medication currently prescribed:

Explain the effectiveness of the treatment or medication in elimination or ameliorating symptoms:

e. Have you ever or are you currently receiving accommodations in a work setting?
☐ Yes
☐ No

If yes, describe the specific accommodation(s): if no, explain why you did not request accommodations or why accommodations were not granted:

I am aware that it is my responsibility to file a COMPLETE Accommodations Eligibility Questionnaire. I understand that it will be returned to me if it is found to be incomplete, untimely or otherwise is not in compliance with the instructions. I agree that all documents supporting my accommodation request may be reviewed by a physician, therapist, or professional authority. I further agree to submit to independent diagnostic testing by a physician, therapist, or professional authority of Utah County Government's choice, if such is requested. I have completed all supporting documentation with this Questionnaire. I CERTIFY the above statements to be true. I understand that false statements made herein could result in denial of accommodations.

Signature:_____

Print Name:_____

Date:_____

Medical Disability Verification Form

To be completed by a Physician or Licensed Professional

This form must be completed by a qualified evaluator who is familiar with the candidate's disability and its impact on the candidate's ability to perform essential job functions. The evaluator should complete all sections of this form, unless it clearly does not pertain to the employee's specific disability. Recommended accommodations must be supported by objective data as well as clinical observations.

Simply being diagnosed with a condition does not entitle an employee to accommodations. Objective data must be provided that specifically demonstrate how the condition impairs the employee so that the appropriate accommodations can be determined.

Please refer to the General Guidelines for Documenting Medical Disability (attached) before completing this form.

Return this form and relevant records to the employee for submission to Utah County Government Human Resources Office.

Name of Employee:_____

Name of professional completing this form:_____

Title:_____

License/Certification Number:_____

Complete Address: _____

_____

_____

Phone Number:_____

Please describe the credential(s) that qualify you to diagnose and/or verify the employee's disability and to recommend accommodations:

INFORMATION REGARDING THE EMPLOYEE

1. Date you first met with patient/employee:_____
2. Date of patient/employee's initial diagnosis:_____

   If you did not make the initial diagnosis, please provide the name of the professional who did:

   _____

   _____

   _____

3. Diagnostic tests administered and dates thereof:

4. Date of last examination/treatment of the patient/employee:_____

5. Utah County Government requires current documentation (within the last 5 years) from a physician or licensed professional relating to the employee's disability to be included with a request for accommodations. Do you have any current medical reports/evaluations on the employee?

   ☐ Yes
   ☐ No

   Please explain:

6. As a result of your examination, tests, and treatments of the patient, what is the specific diagnosis, condition, and/or disability that warrants your recommendation for accommodations:

7. Given the possibility that some individuals may seek a diagnosis of physical deficits in order to inappropriately obtain accommodations, evaluations should include objective assessments to rule out malingering or exaggerated reporting of symptoms. Please describe any objective symptom validity testing that was used to confirm the diagnosis, as well as the result of such testing:

8. Please describe the nature of the condition and how this condition affects the employee, including the impact on daily activities:

9. Please identify the major life activities that are substantially impaired by the employee's condition:

10. Does the severity of the condition/impairment fluctuate?
    ☐ Yes
    ☐ No

    If yes, please describe the settings and/or circumstances affecting severity that are relevant to the essential job functions of the employee:

11. Please describe your treatment of this condition, including any and all prescribed medications:

12. Does the employee experience any side effects as a result of taking prescribed medications and/or other treatment?
    ☐ Yes
    ☐ No

    If yes, please describe the side effects and any impact they may have on the employee's regular activities:

13. Does the medication/treatment prescribed to the employee ameliorate the symptoms?
    ☐ Yes
    ☐ No

    If no, please explain what symptoms continue even with medication:

14. Is this a permanent condition/disability?
    - ☐ Yes
    - ☐ No

    If no, when is this condition/disability likely to abate?

15. Please describe the history of accommodations received by the employee:

16. Based on your knowledge and understanding of the employee's disability, please describe the recommended accommodations that will allow the employee to perform the essential functions of his or her job:

17. Please explain how the recommended accommodation(s) will reduce the impact of the functional limitation the disability imposes:

PHYSICIAN'S SIGNATURE:

I declare that the above information is true and correct.

_____ _____

(Signature of Physician/Licensed Professional) (Date)