Treating Provider Form: With or Without Restrictions
REQUEST FOR REASONABLE ACCOMMODATIONS

PART I: To Be Completed by Employee:

Name: ____ Employee ID: ________________ _

Work Location:_______________________________________ _Position:________________________

Phone Number (Personal): ____________________ Phone Number (Work):_________ _ Email: _ _

_______________________________________ ____

NATURE OF DISABILITY / IMPAIRMENT

Please provide a brief description of your medical condition.

Date of Injury (DOI), if applicable: _ ________________________ _

Date of Disability Onset (DOD), if applicable: ____________________ _

POTENTIAL BENEFITS RELATED TO YOUR DISABILITY:

To help us coordinate between the Office of Benefits Services (Disability and Leaves Unit) and the **Office of Equity and Employee Relations (EER)**, please check all those that apply:

	Intend to Apply for Benefit(s)	Have Applied for Benefit(s)	Currently Receiving Benefit(s)	Previously Received Benefit(s)
Short-Term Disability (STD)				
Long-Term Disability (LTD)				
Workers' Compensation (WC)				
Family Medical Leave (FMLA)				

PLEASE SUBMIT THIS COMPLETED FORM TO: LIBERTY MUTUAL AND TO FCPS EQUITY & EMPLOYEE RELATIONS

Equity & Employee Relations: By fax at 571-423-5051 or by email at EERADA@fcps.edu

Liberty Mutual: For Short and Long Term Disability claims, also return this form to disabilitydocuments@lfg.com or by fax at 603-334-0401; and for Workers Compensation Claims by fax to 603-334-0203 or by email at EZDROP.noreply@libertymutual.com.

RELEASE OF MEDICAL INFORMATION:

Liberty Mutual is a third-party administrator that works with FCPS to provide STD, LTD and WC benefits. Information you provide to Liberty Mutual may also inform your entitlement to other potential benefits, such as FMLA leave, or reasonable accommodations under the Americans with Disabilities Act (ADA). Please confirm, by signing below, that Liberty Mutual may provide FCPS with copies of any medical forms or documentation you provide to it. Any such information received by FCPS will be kept confidential and stored apart from personnel files, and used only as permitted by law.

____

Employee Signature Date

PART II: MUST BE COMPLETED BY EMPLOYEE'S TREATING MEDICAL PROVIDER

Please answer ALL questions completely, sign, and return to: **Equity & Employee Relations (EER)** Fax: 571-423-5051 or by email at EERADA@fcps.edu AND to **Liberty Mutual**: For Short and Long Term Disability claims, also return this form to disabilitydocuments@lfg.com or by fax at 603-334-0401; and for Workers Compensation Claims by fax to 603-334-0203 or by email at EZDROP.noreply@libertymutual.com.

If more space is needed, please use the back or attach extra pages. FCPS and/or Liberty Mutual may require additional information in the future. We hope we can count on your continued assistance. Thank you.

FCPS Employee Name:____

1. Name of employee's medical condition: ____ _

2. Please describe the nature of this employee's medical condition/injury:

_ ____

____

3. How long (a) has the employee had this condition/injury and (b) is it expected to last?

(a) ________________________________ (b) ________________________________

4. Do you characterize this medical condition as (circle one): Mild, Moderate, or Severe?

5. **Which major aspects, if any, of the employee's daily living are limited by his/her medical condition /injury:**
(Circle all that apply)
Major Life Activities: *caring for oneself *performing manual tasks *seeing *hearing *eating *sleeping *walking *standing *lifting *bending *speaking *breathing *learning *reading *concentrating *thinking *communicating *working
Major bodily functions:*the immune system *normal cell growth *digestive *bowel *bladder *neurological *brain *respiratory *circulatory *endocrine *reproductive functions

Other ____ ________

6. Please check the box below to confirm the employee's current return to work status.

☐ Employee may return to work FULL DUTY (WITHOUT restrictions) on (date ____________ _)

☐ Employee may return to work WITH Physical Restrictions on (date ______________) (***Complete Next Sections***)

☐ Employee may return to work WITH Cognitive/Mental Restrictions on (date ____________) (****Same****)

7. If any, indicate the employee's PHYSICAL LIMITATIONS/RESTRICTIONS

Limited Use of Affected Body Part(s):______________________________ Right Left Both

Restrictions as outlined below:

Sitting:_____________hours
Walking:_____________hours
Standing:____________hours

Commercial Driving:______________hours
Driving a Passenger Car:___________hours

Lifting:
Frequently___________pounds
Occasionally_________pounds
Maximum____________pounds

Carrying:
Frequently____________pounds
Occasionally__________pounds
Maximum_____________pounds

Pushing/Pulling
Frequently________________pounds
Occasionally______________pounds
Maximum_________________pounds

Bending/Twisting	Squatting	Crawling	Climbing	Kneeling	Reaching
Not At All	Not At All	Not At All	Not At All	Not At All	Not At All
Occasionally	Occasionall	Occasional	Occasionall	Occasionall	Occasional
Frequently	Frequently	Frequently	Frequently	Frequently	Frequently
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

Working at Heights	Operating machinery	Exposure to Dust/Fumes/Gas
Not At All	Not At All	Not At All
Occasionally	Occasionally	Occasionally
Frequently	Frequently	Frequently
Unlimited	Unlimited	Unlimited

What is the start date of these restrictions? _________________________End date? ________________________

Are there barriers in the employee's ability to return to work that may be resolved with an accommodation? Y / N

If you answered yes to the above question, please list the barriers and recommended accommodation(s) below:

Barriers:____

Recommended accommodation(s): ____

____

What is the expected start and end dates of these recommended accommodations?_____________ to ___________

8. If any, indicate the employee's COGNITIVE/MENTAL RESTRICTIONS

Does employee have any cognitive or mental restrictions? Y / N If yes, please describe:

____

____

What is the start date of these restrictions? ________________________ End date? _______________________

Are there barriers in the employee's ability to return to work that may be resolved with an accommodation? Y / N

If you answered yes to the above question, please list the barriers and recommended accommodation(s) below:

Barriers:____

Recommended accommodation(s):________ ____

____

What is the expected start and end dates of these recommended accommodations?___________to ___________

9. An FCPS Job Specification sheet was included with this form: __Yes _ _No
If yes, please review it and identify any of the functions you believe the employee cannot perform, and why (unless you already have done so in response to an earlier question, then please identify the applicable question number).

____

____

10. Given the limitations cited above, what could FCPS do to assist the employee to perform his or her job functions?

____ _

____

11. Are there any alternative ways to assist the employee? Y / N If yes, what?

____

____

12. Has the treating physician(s) prescribed treatment for this employee (circle one): Y / N If so, describe it:

____ _

Expected Duration (time period or expiration date):____________________________________ ___________ _

13. Are there side effects from this treatment that contribute to the employee's need for an accommodation?
Circle one: Y / N If so, please describe them: ____

____ _

Additional Comments:____ _

____ _ ____________________________

Treating Physician's Signature Date

____ (___) _______-____________

Treating Physician Name (Please Print) Work Phone Number

____ _____________________________ _

Address, City, State, Zip Code

MANAGER INSTRUCTIONS

If an employee has submitted a disability claim, managers may contact Liberty at 1-800-210-0268 to confirm an employee's status. Per FCPS protocol, employees may not return to work unless as part of the reasonable accommodations process through EER or until Liberty forwards information contained in this form or a signed full duty release. If you have not received an email from Liberty with the information contained in this form and have received this form directly from the employee or treating physician, please provide a copy of this form to EER and contact the Liberty case manager at 1-800- 210-0268 to confirm the employee's status and discuss next steps. 76-0083-00 (REVISED 08/2019)