To be completed by your Health Care Provider

CITY OF LITTLE ROCK – REASONABLE ACCOMMODATION HEALTH CARE PROVIDER CERTIFICATION FORM FOR PARKING ONLY

Return completed form to Fax (501) 244-5475, Attention: Labor and Employee Relations Division

EMPLOYEE NAME: _____

JOB TITLE: _____

DATE ACCOMMODATION REQUEST RECEIVED: _____

Authorization to Release Information: I hereby authorize the undersigned physician to release information acquired in the course of my examination or treatment to the Labor and Employee Relations Division-Human Resources Department to determine eligibility for a parking accommodation. I understand that this authorization to disclose information will remain in effect until written revocation is received by my health care provider.

_____ _____

Employee Signature (or Legal Representative's Signature*) Date

_____ _____

*Printed Name of Employee's Legal Representative Relation to Employee

TO BE COMPLETED BY PATIENT'S PHYSICIAN

1) Please review the attached job description. Is the employee able to perform the essential job functions of this position without reasonable accommodation?

Yes No (Please Circle One) - If Yes, no other questions will need to be completed. Please just sign the form and return to the fax number at the top of the page.

2) Does the employee have a physical or mental disability that will interfere with performing one or more of the essential functions of this position?

Yes No (Please Circle One) - If Yes, please describe how the physical or mental disability will interfere with the employee's ability to perform the essential job functions.

_____

_____

_____

3) What reasonable accommodation(s) to the work requirements or position responsibilities would enable the employee to perform the essential functions of that position?

_____

_____

_____

I hereby certify that the individual listed above is or has been a patient under my care and is disabled either permanently or temporally as indicated below:

CIRCLE ONE: PERMANENTLY TEMPORARILY

If temporarily, please indicate how long the patient will need the reasonable accommodation.

_____

If unable to provide a date, when will he or she be medically reevaluated?

_____

Check the appropriate box or boxes which defines the patient's condition(s) **(PLEASE CHECK YES OR NO)**.

- ☐ YES ☐ NO Cannot Walk one hundred (100) feet without stopping to rest:
- ☐ YES ☐ NO Cannot walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device.
- ☐ YES ☐ NO Is this patient capable of walking ¼ mile on pavement with a very slight elevation?
- ☐ YES ☐ NO Is this patient restricted from walking ¼ mile or more? If yes, how many feet can he/she walk?_____
- ☐ YES ☐ NO Do you encourage this patient to occasionally walk ¼ mile or more?
- ☐ YES ☐ NO Is this patient capable of walking 400 feet on a smooth surface with a very slight elevation?
- ☐ YES ☐ NO is this patient restricted from walking 400 feet or more? If yes, how many feet can he/she walk? _____
- ☐ YES ☐ NO Do you encourage this patient to occasionally walk 400 or more feet?
- ☐ YES ☐ NO Is this patient capable of walking 550 feet on a smooth surface with a very slight elevation?
- ☐ YES ☐ NO is this patient restricted from walking 550 feet or more? If yes, how many feet can he/she walk? _____
- ☐ YES ☐ NO Do you encourage this patient to occasionally walk 550 or more feet?

Please attach any additional documentation, comments, or suggestions.

_____ _____

Health Care Provider Name (Printed) Date

_____ _____

Health Care Provider Signature Telephone Number