ATTENDING PHYSICIAN'S STATEMENT

Documenting a disability with a reasonable accommodation under ADA.
(TO BE COMPLETED BY PHYSICIAN or TREATING SPECALIST)

The patient is responsible for completion of this form without expense to the District.
IMPORTANT: Items 7 and/or 8, i f applicable, must be completed on reverse side.

Name of Patient _____ **Date of Birth** ____/____/____
Mo. Day Yr.

Address _____
No. Street City State Zip Code

Name of Employer ROCHESTER CITY SCHOOL DISTRICT **Health Insurance Group/Policy No.** _____

1 HISTORY

(a) When did symptoms first appear or accident happen? Mo. _____ Day _____ Year _____
(b) When did patient cease work because of disability? Mo. _____ Day _____ Year _____
(c) Has patient ever had same or similar condition? ☐ Yes ☐ No
If "Yes" state when and describe. _____
(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
(e) Names and addresses of other treating physicians? _____

2 DIAGNOSIS (Including any complications)

(a) Date of last examination: Mo. _____ Day _____ Year _____
(b) Diagnosis (including any complications): _____
(c) Subjective symptoms: _____
(d) Objective findings (including diagnosis of current X-rays, EKG's, Laboratory Data and any clinical findings):
_____

3 DATES OF TREATMENT

(a) Date of first visit: Mo. _____ Day ___ Year _____
(b) Date of last visit: Mo. _____ Day ___ Year _____
(c) Frequency: ☐ Weekly ☐ Monthly ☐ Other ☐ Specify

4 NATURE OF TREATMENT (Including surgery, physical therapy, counseling, and medications prescribed, if any.)

_____
_____

5 PROGRESS

(a) Has patient ☐ Recovered? ☐ Improved? ☐ Stabilized? ☐ Retrogressed?
(b) Is patient ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined?
(c) Has patient been hospital confined? ☐ Yes ☐ No If "Yes" give name and address of hospital.

_____ Confined from _____ through _____

_____

(over)

6 CARDIAC (If Applicable)

(a) Functional capacity (American Heart Assoc.) ☐ **Class 1** (No Limitation) ☐ **Class 2** (Slight Limitation) ☐ **Class 3** (Marked Limitation) ☐ **Class 4** (Complete Limitation)

(b) Blood Pressure (last visit) Systolic _ Diastolic _

7 PHYSICAL IMPAIRMENT (As defined in Federal Dictionary of Occupational Titles)

❒ Class 1 ➥ No limitation of functional capacity: capable of heavy work. No restrictions (0 -10%).

❒ Class 2 ➥ Medium minimal activity (15-30%).

❒ Class 3 ➥ Slight limitation of functional capacity: capable of light work (35-55%).

❒ Class 4 ➥ Moderate limitation of functional capacity: capable of clerical/administrative (sedentary) activity (60-70%).

❒ Class 5 ➥ Severe limitation of functional capacity: incapable of minimal (sedentary) activity (75-100%).

8 RESTRICTIONS, IF ANY

9 PROGNOSIS

Expected Return to Work Date: _____

Is this a short-term disability? ☐ Yes ☐ No If yes, what is the duration of the disability? _____

Is this a permanent Disability? ☐ Yes ☐ No

10 ACCOMMODATIONS

Expected duration of these accommodations: _____

Is patient totally disabled? (Disability shall mean inability to engage in any substantial, gainful activity by reason of a medically determinable impairment that may be expected to be of long, continued and indefinite duration.)

How long was or will patient be totally disabled? _____

11 REMARKS

Attending Physician or Treating Specialist Name (PRINT) | **Degree** | **Specialty** | **Telephone No.**

Address | **City or Town** | **State** | **Zip Code**

Signature | **Date**

Please Return Completed Form c/o: Rochester City School District
Employee Benefits
131 West Broad Street
Rochester, New York 14614

Phone #: (585) 262-8206
Fax #: (585) 295-2614