

City of Pittsburgh



Health Care Provider Documentation of Disability Form

Section 1: To be completed by the employee

Name: _____

Social Security #: _____ Date of Birth: _____

Department: _____ Job Title: _____

Work Location: _____

I hereby authorize the health care provider(s) referenced on these forms, or any other health care provider who has signed any report relating to this request, or any other health care provider, to release to the City of Pittsburgh Department of Human Resources & Civil Service past and future medical information concerning the disability disclosed herein and to provide opinions for the purpose of determining my ability to perform job-related functions, with or without reasonable accommodation. I further authorize the Department of HR&CS to seek clarification of this documentation if necessary by contacting my attending health care provider.

Employee Signature: _____ Date: _____

Section 2: To be completed by the health care provider

1. Please identify the employee's physical or mental impairment and the anticipated duration of this impairment (i.e. short-term, long-term, permanent, etc.).

2. Please describe the activities that are impacted by the condition identified above:

3. In reviewing the employee's job duties, please describe the essential functions that can not be performed by the employee:

4. For all of the essential functions which require accommodation, indicate possible accommodation(s) and duration which might adequately enable the employee to perform his or her job functions:

Signature of Health Care Provider: _____ Date: _____

Name (please print): _____

Address: _____

Telephone No.: _____

Please return this form to:

Department of Human Resources & Civil Service
City of Pittsburgh
City-County Building
414 Grant Street, Room 431
Pittsburgh, PA 15219

ATTN: Director of Human Resources & Civil Service