AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
Request to Health Care Provider for Information
Supporting Accommodation Request

To: ________________________________(Health Care Provider's Name)
Re: ________________________________ (Patient's Name)
Date: ________________________________

I, ___________________, have submitted a request to the Joint Port Labor Relations Committee in the Port(s) of _______________ for accommodations related to a physical or mental impairment. The collective bargaining agreement governing my employment/potential employment provides for an "interactive process" for evaluating accommodation requests including review of documentation from an employee's/applicant's health care provider. The policy allows for temporary accommodations while the interactive process is in progress.

I have submitted an accommodation request, and asked for a temporary accommodation while the accommodation request is pending. The Joint Port LRC therefore requests that you accurately, completely, and promptly fill out and return the enclosed questionnaire to the Joint Port Labor Relations Committee for the Port of _____________.

I hereby authorize you to respond to this and any other requests by the Joint Port LRC relating to my accommodation request(s).

Thank you for your assistance in this matter.

I understand that I may revoke this Authorization at any time, in a writing delivered to the JPLRC at:
____.
I understand that while my revocation would be effective upon receipt, it will not be effective to the extent anyone has acted in reliance upon this Authorization. I may inspect or obtain a copy of this letter and the information I am asked to have used/disclosed.

Dated: ___________________________ ________________________________
Patient Signature
Patient Name (Printed): ____
Registration/Payroll Number: ____
Street Address: ____
City: ____________________________________ State: _________ Zip Code: ___________
Telephone Number: ________________________

Questionnaire for Health Care Provider in support of Accommodation Request

(*please print* ***clearly --*** attach additional pages if necessary for a complete response).

Date:

Name, Address and Telephone Number of Health Care Provider:

Area(s) of Practice/Specialty:

Name of Employee/Applicant:

1. Are you the employee's/applicant's primary health care provider?

   If so, when did s/he first become your patient?

2. Are you related to the employee/applicant?

3. Have you examined the employee/applicant? **Yes/No** (circle one)
   If so, when was the most recent examination?

4. In your opinion, does the employee/applicant have a physical or mental impairment that limits his or her ability to engage in one or more major life activity? **Yes/No** (circle one)

If yes, please check the activity[ies] limited by the impairment below.

☐ Caring For Self
☐ Interacting With Others
☐ Performing Manual Tasks
☐ Breathing
☐ Working

☐ Walking
☐ Standing
☐ Reaching
☐ Thinking
☐ Toileting

☐ Hearing
☐ Seeing
☐ Speaking
☐ Learning
☐ Sitting

☐ Lifting
☐ Sleeping
☐ Concentrating
☐ Reproduction

☐ Other: (describe)

Questionnaire for Health Care Provider in support of Accommodation Request
(*please print* ***clearly***)

5. If you answered "yes" to number 4, in your opinion, does the employee/applicant have any functional limitations that will limit his/her ability to perform watchmen work due to his or her mental or physical impairment? **Yes/No** (circle one).

If yes:

(a) What are the work-related functional limitations? Please list all, with as much detail about how the functional limitation will limit his/her ability to work as possible. (**This does not request or require disclosure of a diagnosis, or genetic information about the employee/applicant or his/her family**).

(b) How long are the work-related functional limitations anticipated to last?

When would you consider it useful for the employee's/applicant's limitations to be revisited? For example, are the limitations readily correctable (such as by obtaining or updating prescriptions, glasses, hearing aids) or likely to change in a foreseeable period (such as if surgery is scheduled or anticipated)?

(6) Have you attached any additional pages? **Yes/No (circle one)**

_______________________________ Date: ___________________

Signature of Medical Provider