Your patient has requested your assistance in obtaining or maintaining their employment. MDI offers a variety of employment programs that focus on people with disabilities. To ensure that your patient is eligible for one of our programs, MDI needs to verify their disability and the limitations it creates in an employment setting. Therefore, please fill out the next few pages to identify the individual’s diagnosis and areas of limitations. When doing this please indicate the level of physical or mental impairment, which limits the person’s capabilities that the individual may have difficulty in engaging in competitive employment (41 CFR, Section 51-1.3). If the attached forms are not filled out completely, MDI may not be able to provide them employment and the supports necessary to be successful.

**EMEDICAL PROVIDER TO COMPLETEE**

**(Must be filled out by a certified medical provider, typically a Psychologist, Psychiatrist or Medical Physician)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Providers Name:** | | | |  | |  | | | | Title: | |  | | | | |
|  | | |  | | | | |  |  | | | | |  |  | |
|  | | |  | | | | |  |  | | | | |  |  | |
| Provider or Clinic: | |  |  | | | | | Phone: |  | | | | | Fax: |  | |
|  | | |  | | | | |  |  | | | | |  |  | |
|  | | |  | | | | |  |  | | | | |  |  | |
| Address: |  | | | | City: | |  | | State: | |  | | Zip Code: | | |  |

According to the Department of Employment and Economic Development (DEED), the definition of an individual with a most severe disability is the following: *“A severe physical or mental impairment that results in serious limitations to employment in three or more functional areas; (Communication, Interpersonal Skills, Mobility, Self-Care, Self-Direction, Work Skills, or Work Tolerance); whose employment can be expected to require ongoing employment support services over an extended period of time and who has one or more physical or mental disabilities. M. Rules 3300.2005 Subpart 20 & 22.”*

In accordance with the regulations set forth by the AbilityOne Program, please provide supporting documentation for the applicant named on the release of information form.

**EPATIENT INFORMATIONE**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name:** |  | | | | | | | | Date of Birth: | | | |  | | |
|  | | | |  | | |  | | | | |  | | | |
| Primary Diagnosis: |  | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | |
| Secondary Diagnosis: | |  | | | | | | Tertiary Diagnosis: | | |  | | | | |
|  | | | | | | | | | | | | | | | |
| Patient has been under my care from | | | | |  | to | |  | | Date of last exam: | | | |  |

|  |  |  |
| --- | --- | --- |
| Level of impairment; cognitive and/or physical: | |  |
| Functional Capabilities: |  | |

I certify at this time, that the above named individual is a candidate for rehabilitative employment with MDI. This individual would benefit from receiving individualized job supports such as job coaching, case management services and having their accommodations needs met. It is doubtful that they will ever be able to be competitively employed.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(Must be signed by a certified medical provider, typically a Psychologist, Psychiatrist or Medical Physician)***

**Working Conditions: Check any of the following that should be AVOIDED.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Dust | Humid/Wet | | | Odors/Fumes | | Sudden Temperature Changes | | | High Places | |  |  |  |
|  | | |  | |  | | |  | |  | | | |
| Noise | | Outside | | Skin/Irritants/Allergies | | | High/Low Temperatures | | |  | | | |

Please provide further information on the item(s) circled above:

|  |
| --- |
|  |

Difficulty with repetitive motion (hands, wrists, elbows); briefly explain:

|  |
| --- |
|  |

Please list medications that affect the individual’s ability to work:

|  |
| --- |
|  |

This patient can work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours/day\_\_\_\_\_\_\_\_\_\_\_\_ days/week Rotate or change jobs every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours/day

**This patient CAN do the following:**

| **Physical Activity** | **Hours/Day** | **Days/Week** | **Indicate the MAXIMUM tolerance (lbs.)** | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **No limit** | **0-10** | **11-20** | **21-50** | **51-75** | **76-100** |
| Walk |  |  |  |  |  |  |  |  |
| Stand |  |  |  |  |  |  |  |  |
| Stoop/Bend at Knees |  |  |  |  |  |  |  |  |
| Squat/Kneel/Crawl |  |  |  |  |  |  |  |  |
| Climb stairs, steps or ladders |  |  |  |  |  |  |  |  |
| Bend neck forward/upward |  |  |  |  |  |  |  |  |
| Sit |  |  |  |  |  |  |  |  |
| Lift |  |  |  |  |  |  |  |  |
| * Floor to waist |  |  |  |  |  |  |  |  |
| * Overhead reaching |  |  |  |  |  |  |  |  |
| * Outstretched |  |  |  |  |  |  |  |  |
| * Elbow – close to waist |  |  |  |  |  |  |  |  |
| Twist (upper body) |  |  |  |  |  |  |  |  |
| Grasp/Grip (both hands) |  |  |  |  |  |  |  |  |
| Pinch (both hands) |  |  |  |  |  |  |  |  |
| Other (List them below): |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Describe in detail **ANY OR ALL** restrictions and/or limitations that may need accommodations: | Temporary Date Temporary restrictions and/or limitations ends  Permanent |  |
|  |  |  |
|  | | |
|  | | |

**My signature (patient) below indicates that that I understand this document and its purpose:**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(Must be signed by a certified medical provider, typically a Psychologist, Psychiatrist or Medical Physician)***