WELLS FARGO

Healthcare Provider Recommendation for Accommodation

Employee Name: Pankaj Kumar Wells Fargo ID#: 1451883

INSTRUCTIONS FOR THE HEALTH CARE PROVIDER

1. The purpose of this form is to understand how the employee's medical condition impacts their ability to perform their job tasks and identify reasonable accommodations to help them successfully perform their job.
2. Complete each section of this form, and sign and date Section 3. Your answers should reflect your best estimate based upon your medical knowledge, experience, and examination of the patient.
3. **Please do not send any medical records or genetic information.** *All information provided on this form will be treated in a confidential manner in accordance with state and federal confidentiality laws.*

Section 1: Medical Information

1) Does the employee have a chronic or ongoing medical condition/disability, pregnancy or pregnancy-related condition, or lactation need? ☐ Yes ☒ No

2) Approximate date the condition first appeared: 12/01/2022

3) Does the medical condition/disability impact a major life activity? ☐ Yes ☒ No
*(**Major life activities** include, but are not limited to performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, talking, breathing, learning, reading, concentrating, thinking, communicating, and working.)*

4) How long is the employee's medical condition anticipated to impact them? ☐ Ongoing ☒ Temporary
   a. If temporary, anticipated end date : Approximately six months (04/04/2024)

5) How does the employee's medical condition affect their ability to perform the day-to-day functions of their job?

Medical Condition is **GREATER TROCHANTERIC PAIN SYNDROME in the hip** & MUSCLE IMBALANCE/WEAKNESs in the knees. It should not impact patient ability to perform day-to-day functions of the job.

Section 2: Accommodations or Job Modifications

1) Does the patient need an accommodation to assist in performing their job duties? ☐ Yes ☒ No
*(An **accommodation** is a modification or adjustment to a job, work environment, or the way things are usually done to help the employee successfully perform their job tasks.)*

2) Are the recommended accommodations: ☐ Permanent or ☒ Temporary and expire on date: 04/04/2024

What types of accommodation assistance do you think might be helpful for the employee?
Examples of accommodation assistance include but are not limited to: intermittent absences, ergonomic adjustments or equipment; assistive technology software and hardware like screen readers and voice recognition; physical work environment changes, like lighting modifications; work or break schedule changes.*

Due to exacerbation of symptoms with sitting and waking, he may need to limit driving to <30 minutes, or as tolerate

He may require limiting walking to distances tolerated with minimal increase in knee or hip pain. He may otherwise

Walk as tolerated.

*For **intermittent absences or time off for treatment,** complete the following as applicable:

☐ MEDICAL APPOINTMENT TREATMENT TIME OFF REQUIRED

_____ per _____ for _____
number of times *week/month/year* *hours per visit*

☐ FLARE OF CONDITION TIME OFF REQUIRED

_____ per _____ for _____
number of times *week/month/year* *hours per episode*

☐ REDUCED WORK SCHEDULE

_____ for _____ for _____
days per week *hours per day* *number of weeks*

Recommended end date for the time away from work outlined above: _____

Section 3: Healthcare Provider Certification

I certify that the information provided on this form was completed in its entirety by me, or my designee, and that the information is accurate to the best of my knowledge.

Amanda Feeney 9963 Physical therapist
PRINT Name of Healthcare Provider License Number Type of Practice (Specialty)

SIGNATURE of Healthcare Provider 10/18/2023
Date

4123 radio drive Woodbury Mn 55129
Street Address City State Zip

651-968-5765 Afeeney@summitortho.com
Telephone Number Fax Number Email

Employee name: Pankaj Kumar