

Healthcare Provider Medical Accommodation Form

Employee Name:

Richard Steinberg

Wells Fargo ID#:

1796143

INSTRUCTIONS FOR THE HEALTH CARE PROVIDER

- 1) The purpose of this form is to understand how the employee's chronic or ongoing medical condition impacts their ability to perform their job tasks by asking you to provide limitations and restrictions so that reasonable accommodations can be explored 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(s), disability, pregnancy or pregnancy-related condition, or lactation need? ☒ Yes ☐ No
- 2) 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.)

Section 2: Limitations/Restrictions or Time Off/Reduced Schedule

- 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) Provide the limitations/restrictions due to their medical condition(s) that impacts the ability of the employee to perform their essential job functions. (Examples include but are not limited to: unable to sit/stand for long periods of time, inability to focus/concentrate, light/noise sensitivity, no bending or kneeling, unable to see without screen magnifier.)

Richard has chronic lumbar pain. Pain is exacerbated with prolonged sitting, standing and long walks. Recommend Richard continue to be allowed to work from home.

3) Provide the anticipated expiration date for the limitations/restrictions I am re-evaluated on a monthly basis
(Avoid using terms like indefinite, ongoing or unknown. If you are not able to determine, provide a re-evaluation date.)

His condition is chronic, not acute. He is seen monthly for evaluation. Recommended re-evaluation in one year.

4) For **time off or reduced work schedule**, complete the following, if applicable:

☐ Intermittent absence(s) due to flare of condition:

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

☐ Time to attend appointments/treatments:

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

☐ Reduced work schedule:

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

Section 3: Healthcare Provider Certification and Information

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.

Signature of Healthcare Provider

11-6-2025
Date

Dr. Martin Thai
Printed Name of Healthcare Provider

M3402
License Number

Pain Management
Type of Practice (Specialty)

12309 N. Mopac Expy, Austin, TX 78758
Street Address City State Zip

512-206-8000
Telephone Number

Fax Number

Email