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The Standard Life Insurance Company of New York

855.977.7764 Tel 971.321.5727 Fax
PO Box 5031 White Plains NY 10602-9943

Healthcare Provider Questionnaire
ADA Accommodation Medical Certification

*This form must be returned **from your office directly to our ADA Accommodation Service Team via our confidential fax line, 971-321-5727** located in Portland, OR. Please address the cover sheet to "Accommodation Specialist."*

Patient's Name _____

Employer _____

1. For what condition(s) or impairment(s) have you been treating the employee? Please describe. _____

2. What are the employee's current restrictions due to this condition? _____

3. What job duties is the employee having trouble performing due to the impairment or limitations? _____

   Was the employee's job description provided for you to review? ☐ Yes ☐ No

4. Do you have any suggestions for possible accommodations to assist with completion of job duties? ☐ Yes ☐ No

   If yes, what are they? _____

5. a. If you are recommending a medical leave of absence, please specify:

   I recommend continuous leave: From _____ (mm/dd/yy) To _____ (mm/dd/yy)

   What is a reasonable expected Return to Work date? _____

   b. If condition is episodic or intermittent:

   Frequency: Between _____ and _____ times per ☐ week or ☐ month

   Duration: Up to _____ hours or _____ days per episode

   c. If a temporary or permanent job modification is recommended, (work schedule, physical restriction, graduated part-time return to work, etc), please specify. _____

6. What is the expected duration of the condition or impairment?

   Is the impairment temporary? ☐ Yes ☐ No If yes, please specify duration from: _____ to _____

   Is the impairment permanent? ☐ Yes ☐ No

7. Please indicate what date you will re-evaluate the employee for this condition.

Fraud Notice – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Acknowledgement - I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the above fraud notice.

Physician's Signature		Date	
Physician's Name (please print)		Specialty	
Address	City	State	ZIP
Phone No.	Fax No.		

Please fax completed form to: 971-321-5727

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