NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE HEALTH SERVICE

Reinstatement Examination Request

EHS-705 (2/2012)

Please complete Side 1 and have your physician complete Side 2 of this form and return it to:

Medical Director
Employee Health Service
NYS Department of Civil Service
55 Mohawk Street – Suite 201
Cohoes, NY 12047

Please complete this form and send to the Employee Health Service to request a medical evaluation for reinstatement to State service. Such evaluations are available provided the disability which prevented you from reasonably performing the essential duties of your former position has resolved and that you are presently capable of performing all the essential duties of your former position. If you are not capable of reasonably performing all the essential duties of your former position, you should not submit this form. If you believe that you would be able to reasonably perform the essential duties of your former position with a reasonable accommodation, please contact your former agency. Please provide the following information, which will enable us to act on your request:

Last Name	*First name*	*M.I.*

Address	*City*	*State*	*Zip Code*

Social Security #	*Telephone Number* ( )

Former Job Title:

Agency which you were terminated from:

Date of Termination:	*Were you terminated because of an illness or injury covered by Workers' Compensation?* ☐ ***Yes*** ☐ ***No***

Date of recovery from the health condition that caused your termination:

Describe the health condition that prevented you from performing the duties of your job:

Personal Privacy Protection Notification – The information you provide on this form is requested for the principal purpose of conducting a medical evaluation for reinstatement to State service pursuant to Civil Service Law Sections 71, 72 and 73. Failure to provide the information may interfere with our ability to perform such examination. The information will be used in accordance with Public Officers Law Section 96(1) also known as the Personal Privacy Protection Law. The information will be maintained by the Administrator, Employee Health Service, Department of Civil Service, 55 Mohawk Street – Suite 201, Cohoes, NY 12047; telephone (518) 233-3100. For information concerning the Personal Privacy Protection Law, call (518) 457-9375.

You must authorize your treating physician or health care provider to furnish information about your health status on the back of this form. **If you are unable to perform the *full unrestricted duties*** of your position or i**f you have *functional limitations***, your physician or health care provider must complete the appropriate items.

Please print your Physician's Name and Address below:

_____

_____

_____

_____

PLEASE NOTE: REINSTATEMENT EXAMS ARE SCHEDULED AT OUR COHOES, SYRACUSE, HAUPPAUGE OR BROOKLYN CLINICS.

Physician Name and Specialty (Please Print)	Patient Name

Medical condition causing patient to be terminated from work _____

Has such medical condition improved/resolved to no longer prevent patient from performing the duties of his/her position?

☐ Yes ☐ No

Date patient's medical condition improved/resolved and disability ended _____

Please complete the following items with your estimation of this patient's employment capabilities based upon past evaluations.

1. In an ***eight (8) hour*** workday, how many hours can this patient ? (Please check appropriate boxes)

Sit:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ With Rests
Stand:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ With Rests
Walk:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ With Rests

2. Based on your evaluations of this patient, are there any known problems of a general nature that would interfere with this patient returning to work? ☐ No ☐ Yes If yes, please indicate _____

_____

3. Medical diagnosis / current medications: _____

4. **Other Capabilities** (Check the ones most applicable):

Lift	Never	Occasionally (0-33%)	Frequently (34-66%)	Continuously (67-100%)
0-10 lbs	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100 lbs	☐	☐	☐	☐
Carry	**Never**	**Occasionally (0-33%)**	**Frequently (34-66%)**	**Continuously (67-100%)**
0-10 lbs	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100 lbs	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Run	☐	☐	☐	☐
Restrain combative patients or inmates	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate a motor vehicle	☐	☐	☐	☐

Upper Extremities

Can this patient perform repetitive actions such as?

Simple Grasping

RIGHT ☐ Yes ☐ No

LEFT ☐ Yes ☐ No

Pushing and Pulling

LEFT ☐ Yes ☐ No

RIGHT ☐ Yes ☐ No

Fine Manipulation

RIGHT ☐ Yes ☐ No

LEFT ☐ Yes ☐ No

Lower Extremities

Can this patient use feet/legs for repetitive movement as in operation of foot controls and motor vehicles?

Right Extremity ☐ Yes ☐ No

Left Extremity ☐ Yes ☐ No

Simultaneous ☐ Yes ☐ No

5. **Any Work Environment Restrictions?**

Exposure to marked changes in temperature and humidity	☐ Yes	☐ No	If yes, please describe:
Exposure to dust, fumes and gases	☐ Yes	☐ No	
Working at unprotected heights	☐ Yes	☐ No	
Working around or with moving or hazardous machinery	☐ Yes	☐ No	

6. Is this patient ready to return to ***alternate duty***? ☐ Yes ☐ No Date:_____

Is this patient ready to return to ***full duty***? ☐ Yes ☐ No Date:_____

7. Comments:_____

_____/_____/_____

(Physician's *Signature*) **(*Date*)** ***(Physician's Phone #***