Verification of Disability for Job Placement

Dear Physician,

SOAR365® is a 501(c)(3) non-profit organization with a mission to support people with disabilities in leading productive and fulfilling lives. SOAR365's® AbilityOne Program, established by the Javits-Wagner-O'Day Act, provides employment opportunities for Americans with significant disabilities. Among the requirements for SOAR365® to participate in the AbilityOne program, is that 75% of its total direct labor hours must be performed by people who are ***blind or severely disabled.***

Your patient listed below is applying for a job at SOAR365®. We would appreciate your assistance in providing relevant information about your patient's disability as it relates to employment. **SOAR365®** ***is required to have verification of disability signed by a licensed medical doctor or mental health professional capable of making the evaluation stating all diagnoses in order for the candidate to be considered for employment.***

*****Please note: All 5 pages must be returned, and the physician MUST sign page 5*****

If you have concerns regarding the release of this information, please contact Kendall Solo at (804) 665-1200.

Thank you in advance for your support.

Sincerely,

SOAR365®

APPLICANT:
PLEASE SIGN HERE BEFORE FORWARDING TO YOUR PROVIDER

I, _____ give my permission to release medical and/or disability related information to SOAR365® for the purpose of determining my eligibility for employment services, under the AbilityOne program.

Signature: _____ **Date:** _____

3600 Saunders Avenue
Richmond, VA 23227
OFFICE (804) 358-1874 FAX (804) 353-0163

- Pediatric Therapy
- Children & Youth Program
- Adult Programs
- Respite
- Summer Camp
- PARK365
- Workforce Development
- Business Solutions

Physician Assessment

Patient Name:	Date:
Patients DOB:	

Name of Provider Completing Form:
Phone #: E-mail:
Credentials: ☐ MD ☐ Other

Your cooperation in completing this form is vital to our efforts in determining your patients eligibility for employment within the AbilityOne program, and assessing the supports / accommodations that may be needed.

Diagnosis: Present at this time
•
•
•
•

Medications:		
Prescribed	Indications (Purpose)	Side Effects

1. **In a 10-hour workday, patient can stand/walk:**
   ☐No restrictions ☐8-10hrs ☐6-8hrs ☐4-6hrs
   ☐2-4hrs ☐0-2hrs

2. **In a 10-hour workday, patient can sit:**
   ☐No restrictions ☐8-10hrs ☐6-8hrs ☐4-6hrs
   ☐2-4hrs ☐0-2hrs

3. **Patient can lift/carry (check those that apply):**

	80 lbs.	50 lbs.	40 lbs.	30 lbs.	20 lbs.	10 lbs.	5 lbs.
Frequently	☐	☐	☐	☐	☐	☐	☐
Occasionally	☐	☐	☐	☐	☐	☐	☐

4. **Is the patient restricted by environmental factors, such as heat/cold, dust, dampness, heights, chemicals, fumes, gases, odors, mist, noise, vibration, etc.? (If yes, please explain below)**

5. **Patient can use hands for repetitive movement:**

	Simple Grasping	**Pushing & Pulling**	**Fine Manipulation**
Left Hand:			
Continuously (>67%)	☐	☐	☐
Frequently (34-66%)	☐	☐	☐
Occasionally (1-33%)	☐	☐	☐
Never (0%)	☐	☐	☐
Right Hand:			
Continuously (>67%)	☐	☐	☐
Frequently (34-66%)	☐	☐	☐
Occasionally (1-33%)	☐	☐	☐
Never (0%)	☐	☐	☐

6. **Patient can use feet for repetitive movement, such as operating foot controls:**
   Left Foot: ☐Yes ☐No
   Right Foot: ☐Yes ☐No

7. **Patient is able to balance:**
   ☐ Yes
   ☐ No

8. **Patient is able to:**

	Bend	Squat	Kneel	Climb	Reach	Twist	Rotate	Crawl
Continuously (>67%)	☐	☐	☐	☐	☐	☐	☐	☐
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (1-33%)	☐	☐	☐	☐	☐	☐	☐	☐
Never (0%)	☐	☐	☐	☐	☐	☐	☐	☐

9. **Is patient involved with treatment and/or medication that might affect his/her ability to work?**

☐No

☐Yes; Explanation:

10. **Does patient have other limitations?**

☐	Reading	☐	Learning	☐	Written Directions
☐	Comprehension	☐	Memory	☐	Oral Directions

11. **Will patient be required to use any assistive devices or braces?**

☐No

☐Yes; Explanation:

12. **Does the patient have a hearing impairment?**

13. **Primary mode of communication:**

☐Sign Language ☐Lip Reading ☐ Loud Voice ☐Hearing Aids

14. **Is employee's condition expected to be permanent or temporary?**

15. **If temporary, how long is the condition expected to last?**

(This section applies to those with visual impairments)

If client is visually impaired, does he/she meet the AbilityOne definition of blindness below?

Definition: "An individual or class of individuals whose central visual acuity does not exceed 20/200 in the better eye with correcting lenses or whose visual acuity, if better than 20/200, is accompanied by a limit to the field of vision in the better eye to such a degree that its widest diameter subtends an angle no greater than 20 degrees."

☐ Yes, my patient meets this definition ☐ No, my patient does not meet this definition

	Left	Right	With/without corrective lenses
Central Visual Acuity	☐	☐	
Extent of Peripheral Vision	☐	☐	
Field of Vision	☐	☐	

16. Additional Comments:

If your medical file contains a psychological evaluation or psychiatric evaluation, please include it as supporting documentation.

Physician Information (Please print clearly)

Practice Name and Address:

_____

_____

Practice Specialty: _____

Signature: _____ Date: _____