SKOOKUM

Medical Professional Statement

The AbilityOne® Program is one of the nation's largest sources of employment for people who are blind or have significant disabilities. This Federal Program is administered by the U.S. AbilityOne Commission, the operating name for the Committee for Purchase from People Who Are Blind or Severely Disabled. Additional information on the Program can be found at www.abilityone.gov.

Skookum, a qualified nonprofit agency operating within the AbilityOne® Program, affirmatively hires persons with significant disabilities. Skookum has provided this **Medical Professional Statement** form to assist persons interested in the Program's employment opportunities, and their medical providers, with submitting all necessary information for consideration.

The information provided on this form will specifically be used to determine an individual's eligibility for employment opportunities based on identification of (1) significant disability and (2) the ability to find and maintain competitive employment outside of the Program without support.

The definition of severe disability used for purposes of this Program is found below.

Definition of Disability (41 CFR 51-1.3)
Other severely disabled and severely disabled individuals (hereinafter persons with severe disabilities) mean a person other than a blind person who has a severe physical or mental impairment (a residual, limiting condition resulting from an injury, disease, or congenital defect) which so limits the person's functional capabilities (mobility, communication, self-care, self-direction, work tolerance or work skills) that the individual is unable to engage in normal competitive employment over an extended period of time. "Severely disabled individual; Severe disability; Significantly disabled individual; Significant disability;" are interchangeable or synonymous terms used within the AbilityOne Program to describe persons with severe disabilities who qualify to participate in the AbilityOne Program.

Skookum is required to obtain documentation of a significant disability as per US AbilityOne Commission Policy 51.408.

Accepted Credentials to Complete Form (US AbilityOne Commission Policy 51.408)
This form must be completed by a licensed physician, psychiatrist, psychologist, or other appropriate medical professional not affiliated with the non-profit agency, who is qualified to make a diagnosis of the individual's disabling condition(s), which reflects the nature and extent of the disabling condition(s).

Medical professionals who meet the above credentials may provide their own official forms or medical reports as long as the documentation provides the determined diagnos(es) and full contact information, to include:

- Legible, full name of the licensed professional; and
- Name and address of the licensed professional's practice; and
- Contact information for licensed professional or practice; and
- Signature (electronic or ink) and date.

Skookum
4525 Auto Center Way
Bremerton, WA 98312
360-475-0756

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MEDICAL INFORMATION

1. Individual's Name:

2. Individual's Date of Birth / /

3. The individual has been diagnosed with the following (required):

Nature of Disability *(Diagnosis):*	Extent of Disability	Functional Limitations (Check all that apply):
	☐ Permanent ☐ Temporary ☐ Partial ☐ Total ☐ Indeterminate	☐ Mobility ☐ Communication ☐ Self-Care ☐ Self-Direction ☐ WorkTolerance ☐ Work Skills

Please provide any additional information concerning extent of disability and/or functional limitations that you deem necessary:

Nature of Disability *(Diagnosis):*	Extent of Disability	Functional Limitations (Check all that apply):
	☐ Permanent ☐ Temporary ☐ Partial ☐ Total ☐ Indeterminate	☐ Mobility ☐ Communication ☐ Self-Care ☐ Self-Direction ☐ WorkTolerance ☐ Work Skills

Please provide any additional information concerning extent of disability and/or functional limitations that you deem necessary:

Nature of Disability *(Diagnosis):*	Extent of Disability	Functional Limitations (Check all that apply):
	☐ Permanent ☐ Temporary ☐ Partial ☐ Total ☐ Indeterminate	☐ Mobility ☐ Communication ☐ Self-Care ☐ Self-Direction ☐ WorkTolerance ☐ Work Skills

Please provide any additional information concerning extent of disability and/or functional limitations that you deem necessary:

Nature of Disability *(Diagnosis):*	Extent of Disability	Functional Limitations (Check all that apply):
	☐ Permanent ☐ Temporary ☐ Partial ☐ Total ☐ Indeterminate	☐ Mobility ☐ Communication ☐ Self-Care ☐ Self-Direction ☐ WorkTolerance ☐ Work Skills

Please provide any additional information concerning extent of disability and/or functional limitations that you deem necessary:

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Individual's Name:

Individual's Date of Birth / /

Nature of Disability *(Diagnosis):*	Extent of Disability	Functional Limitations (Check all that apply):
	☐ Permanent ☐ Temporary ☐ Partial ☐ Total ☐ Indeterminate	☐ Mobility ☐ Self-Direction ☐ Communication ☐ Work Tolerance ☐ Self-Care ☐ Work Skills
Please provide any additional information concerning extent of disability and/or functional limitations that you deem necessary:		

Special Accommodations/Comments:

4. It is my professional opinion that the above-named individual has a (1) significant disability and (2) the need for assistance to find and maintain competitive employment outside of the AbilityOne program and (3) would benefit from a program that assists with employment, training, and support. **(Response to this question is optional):**

☐ **Yes** ☐ **No**

5. Professional Identification (required)

Printed Name of Medical Professional:

Name of Practice:

Address and Phone:

License Number:

Signature and Title of Medical Professional:

Date:

A stamp with Practice Name, Address and Phone is acceptable Here

Skookum will securely store the medical professional statement in compliance with Health Insurance Portability and Accountability Act's Security Standards for the Protection of Electronic Protected Health Information.

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