NYC DCAS
Citywide Administrative Services

Dawn M. Pinnock
Commissioner

Barbara Dannenberg
Deputy Commissioner
Human Capital

Medical Appeals and Reinstatements Sections 71/72/73

Please ensure to submit the following with your Application for Reinstatement:

- DCAS' Application for Medical Reinstatement Form
- Employee Medical History & Physician's Certification for Medical Reinstatement Form (dated within 2 months of your application)
- Medical Records: supporting recent & relevant medical documentation, X- Ray reports, MRI reports, Physical therapy records, operative reports, surgical summaries and Psych documentation should include: progress notes (visit dates), treatment and recovery reports, psych summaries
- Appointing Agency's Termination Letter
- A copy of Workers' Comp. Reports (if available – Section 71 cases)
- A copy of the Tasks & Standards (if available)
- A copy of Attachment A (written notice of the facts providing the basis for the judgement that the employee is not fit to perform the essential functions of his/her position) Medical Report (when employee was placed on a Section 72 leave)

All documents can be mailed to 1 Centre Street, 21st floor, New York, NY 10007 or faxed to 212-313-3296 or emailed to mar@dcas.nyc.gov

➢ **If you would like to speak to someone when dropping off your Reinstatement package, please contact the number below and make an appointment.**

If you have additional questions, please contact the Office of Medical Appeals and Reinstatements at 212-386-1704.

Thank you,

DCAS OFFICE OF MEDICAL APPEALS AND REINSTATEMENTS

NEW YORK CITY DEPARTMENT OF
CITYWIDE ADMINISTRATIVE SERVICES

Office of Medical Appeals and Reinstatements
1 Centre Street 21st Floor
New York, New York 10007
PHONE: (212) 386-1704 F A X : (212) 313-3296 E M A I L :
mar@dcas.nyc.gov

EMPLOYEE MEDICAL HISTORY & MEDICAL PROVIDER'S CERTIFICATION

For Reinstatement from Disability Leave

TO BE COMPLETED BY EMPLOYEE'S PERSONAL MEDICAL PROVIDER

MEDICAL HISTORY & STATUS OF:

EMPLOYEE NAME

CIVIL SERVICE TITLE AGENCY

PLEASE WRITE CLEARLY – ATTACH ADDITIONAL PAGES TO THIS FORM IF NECESSARY

STATE NATURE AND DURATION OF EMPLOYEE'S DISABILITY: Give diagnosis and fully describe the disability, treatment, and recovery related to his/her separation from employment.

ETIOLOGY / CAUSATION: **DATE OF LAST EXAMINATION:**

IN YOUR OPINION, IS THE EMPLOYEE'S DISABILITY PERMANENT? YES [ ] NO [ ] (IF YES, PLEASE EXPLAIN)

IN YOUR OPINION, AFTER READING THE EMPLOYEE'S JOB SPECIFICATION, IS THE EMPLOYEE FIT TO PERFORM THE ESSENTIAL DUTIES OF HIS/HER POSITION & SHOULD BE REINSTATED? YES [ ] N O [ ] (PLEASE EXPLAIN)

IN YOUR OPINION, DOES THE EMPLOYEE REQUIRE A REASONABLE ACCOMMODATION TO PERFORM HIS/HER DUTIES? YES [ ] N O [ ] IF YES – PLEASE COMPLETE THE "REASONABLE ACCOMMODATION REQUEST FORM" YOU SHOULD PROVIDE A TIMEFRAME OR AN END DATE FOR THE RESTRICTIONS PLACED UPON THE EMPLOYEE and PROVIDE DETAILS OF RESTRICTIONS.

IMPORTANT IMPORTANT

PLEASE ATTACH COPIES OF APPLICABLE SUPPORTING MEDICAL / PSYCH DOCUMENTATION:
(e.g. X-RAY / CT / MRI Reports, EKG / Stress / Blood Test results, Surgical or Psych Summaries, etc.)

MEDICAL PROVIDER'S CERTIFICATION: I affirm that **I have personally examined the above-named employee and am aware of the essential functions of his/her position.** I understand that the employee has been placed on a leave of absence from that position because of disability. I understand that the information provided by me will be used to determine if the employee is now fit to perform the duties of that position and should be reinstated. By signing below I am certifying that the information provided is true and complete, and I understand that any false statements or deliberate misinformation may be punishable under section 210.45 of the NYS Penal Law, including fines. In addition, I understand that any false statements made will be reported to the NYS Department of Health, Office of Professional Medical Conduct.

SIGNATURE OF MEDICAL PROVIDER **NAME OF MEDICAL PROVIDER (Please Print)** **PROFESSIONAL LICENSE #**

DATE **ADDRESS** **TELEPHONE NO.**

NOTE TO THE MEDICAL PROVIDER: This form is being submitted in conjunction with an application for employment reinstatement pursuant to Sections 71-73 of the New York State Civil Service Law. The applicant will also be assessed by a Medical Officer designated by the NYC Department of Citywide Administrative Services. It is important that you, as the employee's personal medical provider, thoroughly and accurately complete the information above.

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APPLICATION FOR REINSTATEMENT FROM DISABILITY LEAVE

TO BE COMPLETED BY EMPLOYEE

PURSUANT TO SECTION 71, 72 OR 73 OF THE NEW YORK CIVIL SERVICE LAW

INSTRUCTIONS:

ALONG WITH THIS APPLICATION FOR REINSTATEMENT, EMPLOYEE MUST INCLUDE:

- **A DCAS MEDICAL HISTORY FORM FROM YOUR MEDICAL PROVIDER DATED WITHIN TWO (2) MONTHS OF THIS APPLICATION, STATING THAT YOUR DISABILITY HAS ENDED AND/ OR THAT YOU CAN NOW FULLY PERFORM THE ESSENTIAL TASKS AND FUNCTIONS OF YOUR POSITION.**
- **COPIES OF APPLICABLE SUPPORTING MEDICAL/ PSYCHOLOGICAL DOCUMENTATION CONCERNING YOUR MEDICAL HISTORY, DISABILITY, TREATMENT AND RECOVERY (RECENT AND RELEVANT TO YOUR SEPARATION FROM CITY SERVICE.) *ALL PROGRESS NOTES/SUMMARY REPORTS MUST BE LEGIBLE***
- **A COPY OF THE LETTER FROM YOUR AGENCY THAT PLACED YOU ON A LEAVE OF ABSENCE OR TERMINATED YOUR EMPLOYMENT.**

PLEASE COMPLETE THE INFORMATION BELOW AND MAIL WITH ATTACHMENTS TO:

Office of Medical Appeals & Reinstatements, Department of Citywide Administrative Services ("DCAS")
1 Centre Street, 21st Floor New York, New York 10007, within one (1) year from the date your disability ended.

LAST NAME	FIRST NAME	DATE

ADDRESS	PHONE

CITY / TOWN	STATE	ZIP

SOCIAL SECURITY NUMBER	YOUR AGENCY	CURRENT EMAIL ADDRESS

TITLE	DISABILITY/ REASON FOR SEPARATION

NOTATION FIELD
(LEAVE BLANK)

NOTATION FIELD
(LEAVE BLANK)

PLEASE NOTE:

SECTION 71-73 RIGHTS APPLY ONLY TO PERMANENT, COMPETITIVELY APPOINTED, EMPLOYEES OF THE CITY OF NEW YORK. SECTION 71-73 RIGHTS DO NOT APPLY TO EMPLOYEES SERVING WITHIN THEIR PROBATIONARY PERIOD.

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REASONABLE ACCOMMODATION REQUEST FORM

TO BE COMPLETED BY EMPLOYEE'S PERSONAL MEDICAL PROVIDER

LAST NAME	FIRST NAME	DATE

1. **Did you review the Title Specifications (job description) for the employee's title?**

2. **Describe the nature of the reasonable accommodation required and how the accommodation will permit the employee to perform the essential tasks of the position. Please be specific:**

3. **Are there alternative accommodations that would also allow the employee to perform the duties of the position? If so, please specify:**

4. **Is the accommodation requested:** ____ **Permanent** _____ **Temporary**

5. **If temporary, how long will the accommodation (s) be needed:**

SIGNATURE OF MEDICALPROVIDER	NAME OF MEDICAL PROVIDER (Please Print)	NYS PROFESSIONAL LICENSE #
DATE	ADDRESS	TELEPHONE NO.