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1 Centre Street  
New York, NY 10007

[nyc.gov/dcas](http://nyc.gov/dcas)

## 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/psych documentation (progress notes), MRI reports, Physical therapy records, operative reports
- 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, 21<sup>st</sup> floor, New York, NY 10007 or faxed to 212-313-3296 or emailed to [mar@dcas.nyc.gov](mailto:mar@dcas.nyc.gov).

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

If you have additional questions please contact Pamela Ramos 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 14th Floor
New York, New York 10007

PHONE: (212) 386-1704 FAX: (212) 313-3296 EMAIL: mar@dcas.nyc.gov

EMPLOYEE MEDICAL HISTORY & PHYSICIAN'S CERTIFICATION
For Medical Reinstatement

TO BE COMPLETED BY EMPLOYEE'S PERSONAL PHYSICIAN/ PSYCHIATRIST (IF APPLICABLE)

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, IS THE EMPLOYEE FIT TO PERFORM THE ESSENTIAL DUTIES OF HIS/HER POSITION & SHOULD BE REINSTATED? YES [ ] NO [ ] (PLEASE EXPLAIN)

IN YOUR OPINION, DOES THE EMPLOYEE REQUIRE A REASONABLE ACCOMMODATION TO PERFORM HIS/HER DUTIES? YES [ ] NO [ ] (PLEASE EXPLAIN) IF YES - PLEASE PROVIDE A TIMEFRAME OR AN END DATE FOR THE RESTRICTIONS PLACED UPON THE EMPLOYEE and PROVIDE DETAILS OF RESTRICTIONS.

IMPORTANT

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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.)

PHYSICIAN'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 PHYSICIAN

NAME OF PHYSICIAN (Please Print)

NYS PROFESSIONAL LICENSE #

DATE

ADDRESS

TELEPHONE NO.

NOTE TO THE PHYSICIAN: 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 certifying Physician/ Medical Officer designated by the NYC Department of Citywide Administrative Services. It is important that you, as the employee's personal physician, thoroughly and accurately complete the information above.



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APPLICATION FOR MEDICAL REINSTATEMENT

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 PHYSICIAN (PSYCHIATRIST IF APPLICABLE) 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.)
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:

Medical Appeals & Reinstatements, Department of Citywide Administrative Services ("DCAS")
1 Centre Street, 14th Floor New York, New York 10007, within one (1) year from the date your disability ended.

Form with fields: 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)

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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.