



Accessible Parking Permit Accommodation Medical Statement Form

Section 1: For Completion by the UNIVERSITY AFFILIATE
Name: D.O.B.:
Job Title: Department:
I authorize my medical provider(s) to complete this form for the purpose of exploring coverage and reasonable accommodations under University Policy, Fayetteville Policies and Procedures 203.1 Accommodations for Disabilities - Employment, Programs and Services.
Signature: Date:
University affiliates will need to provide their healthcare provider with a copy of their current job description. If you do not have your job description one can be provided for you by OEOC.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we ask that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member, or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Section 2: For Completion by the HEALTHCARE PROVIDER
I hereby certify that the individual listed above is or has been a patient under my care. The information provided herein is based upon my knowledge of the patient's physical and/or mental impairment(s).
Physician Name: Phone Number:
Specialization/Type of Practice: Fax Number:
Business Address:
Physician's Signature: Date:
Your patient is an affiliate of the University of Arkansas and has requested an accommodation. To assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer the questions on this form to help determine if there is a disability and potential reasonable accommodation(s). To expedite the processing of your patient's request for an accommodation, please be as complete and specific as possible. Attach additional sheets if more space is needed.
For a reasonable accommodation under the ADA, an individual has a disability when an impairment that substantially limits one or more major life activities or a record of such impairment. The following questions may help determine whether an employee has a disability.
When completed, please sign and either return the form to your patient, fax to University of Arkansas, Office of Equal Opportunity and Compliance, 479.575.7637, or scan and email to access@uark.edu.
1. Does the patient have a physical or mental impairment? Yes [] No []
2. Is the impairment(s) (diagnosis) or medical condition(s) permanent? Yes [] No []
a. If not permanent, how long will the impairment (diagnosis) or medical condition likely last? # of days # of weeks # of months # of years



b. Is this a condition(s) which may cause episodic rather than a continuing period of incapacity? Yes No

c. Is the patient taking medications or treatments that would be expected to affect job performance, or would pose a direct threat or safety risk to the patient or other people (e.g., co-workers, the general public, etc.)?

Yes No

i. If yes, please explain the threat and any reasonable accommodation that would eliminate or reduce the threat to an acceptable level:

3. Check the appropriate box or boxes, which defines the patient's condition(s).

- Cannot walk one hundred (100) feet without stopping to rest;
- Cannot walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device;
- Is restricted by lung disease to such an extent that the person's forced respiratory expiratory volume for one (1) second, when measured by spirometry, is less than one (1) liter, or the arterial oxygen tension is less than sixty (60) mm/hg on room air at rest;
- Uses portable oxygen;
- Has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association;
- Spinal cord injury;
- Genetic ambulatory disorder;
- An amputation;
- Spina bifida;
- Multiple Sclerosis;
- Chronic heart disease;
- Other (If none of the conditions above applies, list the medical condition that substantially impacts the patient's mobility.):