DISABILITY ACCOMMODATION REQUEST FORM AND MEDICAL STATEMENT

University Staff or Academic Employee

COMPLETION BY MEDICAL PROVIDER: Your patient is an employee of the University of Arkansas and has requested an accommodation. In order to expedite the processing of your patient's request for an accommodation, please be as complete and specific as possible. Please attach additional sheets if more space is needed. When completed, please sign and return the form to your patient and/or fax to University of Arkansas, Office of Equal Opportunity and Compliance, 479.575.7637

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 I – HEALTH CARE PROVIDER INFORMATION | Completed by the Health Care Provider

1. Patient's Name:		
2. Health Care Provider's Name:		3. Title:
4. Address:	5. Phone Number:	6. Fax Number:
7. Brief Description of Practice:		

UNIVERSITY OF ARKANSAS

Office of Equal Opportunity and Compliance

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SECTION II – INFORMATION REGARDING IMPAIRMENT(S) OR CONDITION

8. Does your patient have any physical or mental impairment(s)?	Please Select
If yes, please state the impairment(s):	

9. Indicate each major life activity limited by the physical or mental impairment listed in questions #1.

Here is a non-exhaustive list of examples: Non-exhaustive list of examples: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, working, intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities and operations of major bodily functions such as functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, hemic, lymphatic, musculoskeletal, reproductive functions and operations of an individual organ within a body system (e.g. kidney, liver, or pancreas).

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10. What duration or expected duration of the employee's impairment?
11. Please specify how and to what degree your patient is limited in each of the life activities identified in question #3. For example: lifting was identified as a limited life activity, how many pounds can your patient lift frequently/occasionally? If working was identified, please specify the class of jobs or broad range of jobs that your patient is unable/able to perform. If performing manual tasks was identified, please specify the tasks that are important to most people's daily lives that your patient is unable/able to perform.

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12. Do the limitations you previously identified restrict your patient's ability to perform the job or comply with the requirements of the position? Please review the patient's job requirements in the employee's job description.	Please Select Yes / No
14. Describe any reasonable accommodations that would allow the employee to perform the job functions indicated in previous question. If medical leave is a recommendation, please provide an estimate duration for the leave. If Intermittent leave is needed such as for medical appointments, please indicate the frequency.	
15. In your opinion, if your patient cannot perform their current job with or without a reasonable accommodation, would your patient be able to work in another type of position?	Please Select Yes / No
If yes, please specify what other type of position or work the patient could do:	

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<table>
<tr><td colspan="2"></td></tr>
<tr><td>16. Would performing any job function listed in the employee's job description result in a direct safety or health threat to the employee or other people (co-workers, the general public etc.)</td><td>Please Select

Yes / No</td></tr>
<tr><td colspan="2">If yes, state which job functions would pose a threat, what that threat could be, and any reasonable accommodation that would eliminate or reduce the threat to an acceptable level.):</td></tr>
<tr><td colspan="2">The individual named above is my patient. The information provided here is based upon my knowledge of the patient's physical or mental impairment.</td></tr>
<tr><td>Signature of Health Care Provider:</td><td>Date:</td></tr>
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