UNIVERSITY OF ARKANSAS

OFFICE OF EQUAL OPPORTUNITY AND COMPLIANCE

DISABILITY ACCOMMODATION REQUEST FORM AND MEDICAL STATEMENT
University Staff or Academic Employee

(This form must be completed in its entirety by your licensed treating health care provider.)

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. 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.

Employee: _____ D.O.B.: _____

A. Determining Whether an Employee Has a Disability
For reasonable accommodation under the ADA, an employee 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:
1. Does the employee have a physical or mental impairment? Yes ☐ No ☐ a. If *yes*, please state the name of the impairment or medical condition?
2. What is the duration or expected duration of the employee's impairment? *Please explain if duration of impairment and need for accommodation is different.*
Please answer the following questions based on what limitations the employee has when s/he is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, assistive technology, auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy.
3. Does the impairment substantially limit a major life activity? Yes ☐ No ☐

a. If *yes*, what major life activity/ies is/are affected?

☐ Bending	☐ Hearing	☐ Performing manual tasks	☐ Sleeping
☐ Breathing	☐ Interacting with others	☐ Reaching	☐ Speaking
☐ Caring for oneself	☐ Learning	☐ Reading	☐ Standing
☐ Concentration	☐ Lifting	☐ Seeing	☐ Thinking
☐ Eating	☐ Organic brain syndrome	☐ Sitting	☐ Walking
			☐ Working
☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special sense organs & skin
☐ Cardiovascular	☐ Hemic	☐ Normal cell growth	
☐ Circulatory	☐ Immune	☐ Operation of an organ	
☐ Other:			

B. Need for Accommodation

The following questions may help determine whether the requested accommodation is needed because of the disability (If the symptoms of the condition come and go or are in remission, describe the limitations during an active episode (e.g., seizure, anxiety, *etc*.)):

1. **What** limitation(s) is (are) interfering with the employee performing the job functions or accessing benefits of employment? (Please refer to the employee's job description.)

2. **What** job function(s) or benefits of employment is the employee having an issue performing or accessing because of the limitation(s)? (Please refer to the employee's job description.)

3. **How** does the employee's limitation(s) interfere with the employee's ability to perform the job functions or access benefits of employment? (Please refer to the employee's job description.)

C. Effective Accommodation Options

The following information may help determine effective accommodation(s):

1. Describe any possible accommodations that would allow the employee to perform the job functions or access benefits of employment. *Please be specific, e.g., weight and time limits for mobility restrictions, functional features for office equipment, etc.* (attach addition pages as necessary).

   For a *Leave of Absence or Intermittent Leave recommendation*, please skip this section and go to #2

2. If Leave is identified as an accommodation, please state:
a. For a **LEAVE OF ABSENCE**
1. Please provide the estimated duration for the leave/return to work date
2. Please explain the likelihood of employee being able to return from leave
3. Please explain how leave will facilitate the employee's ability to be able to return to work
b. For **INTERMITTENT LEAVE** (*e.g.*, for episodic conditions or medical appointments)
1. Please provide the units of time (*i.e.*, hours, days, weeks, *etc*.) needed
2. Please provide the frequency (*i.e.*, weekly, monthly, *etc*.) needed

3. Provide the expected duration of the need for intermittent leave (*e.g.*, 3 months)

D. Additional Questions

1. 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 (*e.g.*, co-workers, the general public, *etc*.)?

   Yes ☐ No ☐

   a. If yes, please state which job functions would pose a threat, what that threat might be, and any reasonable accommodation that would eliminate or reduce the threat to an acceptable level:

2. In your opinion, if your patient cannot perform her/his current job with or without a reasonable accommodation, would your patient be able to work in another type of position.
   Yes ☐ No ☐ N/A ☐

   a. If *yes*, please specify what other type of position(s) or work the patient could do:

E. Health Care Provider's Name/Signature

The individual named above is my patient. The information provided herein is based upon my knowledge of the patient's physical and/or mental impairment(s).

_____ _____

Health Care Provider (Print name) Date

_____

Health Care Provider (Signature)

_____

Address

_____

Telephone, fax, email

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.