UNIVERSITY OF ARKANSAS | Chancellor Equal Opportunity & Compliance

Employee Leave or Remote Work Accommodation Request Form

Section 1: For Completion by the **EMPLOYEE** or **PREPARER**	
Employee's Name:	Employee's Email:
Preparer's Name (if other than Employee):	Employee's Phone:
Do you (the Employee) have limited access to email? Official notifications regarding this report will be sent via email. If you have limited or do not have access to email you will be required to provide a mailing address. Yes ☐ No ☐	
Employee's Address:	Employee's City/State:
Employee's Job Title:	Employee's Department:
Employee Supervisor's Name:	
I (the Employee) certify that I have read and understood the information provided in this request, and that it is true to the best of my knowledge, information and belief. I (the Employee) understand that the University reserves the right to request medical documentation to verify the existence of a disability; and, to appropriately assess your condition, functional limitations, and/or request for reasonable accommodation.	

Employees may consult with the ADA Coordinator as to whether the Medical Statement Form is required for their request. The ADA Coordinator will contact the medical provider if additional information is needed to determine if the individual has a disability defined by the ADA or to assist in determining an effective reasonable accommodation.	
Employee Signature:	Date:
Preparer's Signature (if other than Employee):	Date:

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 **Employee** or **PREPARER**

When completed, please sign and either return the form in person, fax to University of Arkansas, Office of Equal Opportunity and Compliance at 479.575.7637, or scan and email to access@uark.edu.

1. Is the request time sensitive? Yes ☐ No ☐
   a. If yes, please explain why the request is time sensitive:

2. Nature of Disability:
   Mental ☐ Physical ☐ Pregnancy Related ☐

3. Impairments/Condition(s): Please identify the impairment(s)/condition for which you are requesting an accommodation:

4. Are you requesting Remote Work as an Accommodation? Yes ☐ No ☐

Please refer to the Remote Work policy: https://vcfa.uark.edu/fayetteville-policies-procedures/hmrs/4123.php

5. Are you requesting Leave as an Accommodation?
   Yes ☐ No ☐
   a. If yes, what is the time frame for which you are requesting?
      Beginning Date: End Date:
   b. If yes, are you currently on FMLA, Short-Term Disability, Catastrophic Leave or using accrued sick and/or vacation leave? Yes ☐ No ☐
      i. If yes, what is the anticipated date of return (the day your leave will exhaust)?
      ii. If no, have you been denied or are ineligible for FMLA, Short-Term Disability, Catastrophic Leave or do not have accrued sick or vacation leave? Yes ☐ No ☐

6. Daily Functions: Describe your normal workday and the areas where you would need an accommodation. Please describe the accommodation being requested:

7. Please explain how the requested accommodation would assist you in performing your job duties:

8. Have you requested assistance from your supervisor or department representative for this particular concern?
   Yes ☐ No ☐

   If yes, what was the outcome from the department?

If your disability/impairment is not obvious or visible, to assist in responding to your accommodation request in a timely manner, please attach the completed appropriate form for your accommodation request:

- Employee Leave or Remote Work Medical Statement Form (for leave accommodations only, downloadable form to be submitted to Medical Provider and attached to the Accommodation Request Form)

If you have completed the appropriate form above and are not able to upload the document, it can be faxed to 479.575.7637 or mailed to 346 N. West Avenue 4 WAAX Fayetteville, AR 72701 or through University Mail at mail stop 4 WAAX. If you have any questions, please contact the ADA Coordinator at 479.575.6208 or access@uark.edu.

For any other review that requires attachments, please attach your supporting documentation.