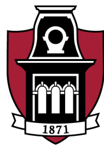


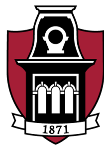
Employee Leave Accommodation Addendum
Medical Statement Form

Section 1: For Completion by the **EMPLOYEE**	
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	
Employee Signature:	Date:
This form is solely for leave related accommodations. The information provided is an addendum to the Employee Accommodation Medical Statement Form that has been previously provided, without the requested leave accommodation information.	

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**	
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).	
Physician Name:	Phone Number:
Specialization/Type of Practice:	Fax Number:
Business Address:	
Your patient is an employee of the University of Arkansas and has requested an accommodation. In order 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.	



UNIVERSITY OF ARKANSAS | **Chancellor** *Equal Opportunity & Compliance*

For a 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.

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 employee have a physical or mental impairment? Yes ☐ No ☐
   - **a.** *If yes*, please state the name of the impairment(s) (diagnosis) or medical condition(s).

Section 2: For Completion by the **HEALTHCARE PROVIDER**

2. Please provide the estimated duration for the leave request.
   - a. Beginning date to End date
   - b. If end date is unknown, please state the beginning date (above) and the estimate of the following duration: # of hours, # of days, # of weeks, or # of months

i. Frequency of duration:
☐ daily, ☐ weekly, or ☐ monthly

ii. If specific days of the week are known for the leave request, please select:
☐ Monday, ☐ Tuesday,
☐ Wednesday, ☐ Thursday, ☐ Friday

3. Please explain how being granted leave as an accommodation will aide in the employee's ability to return back to work.

4. Do you have any suggestions regarding possible additional accommodations that would enable the employee to perform their essential job functions or access benefits to employment?
Yes ☐ No ☐

a. If yes, what accommodations or adjustments to the work environment or position responsibilities would enable the employee to perform their essential job functions or access benefits to employment? *Please be specific, e.g., weight and time limits for mobility restrictions, functional features for office equipment, etc.* (attach addition pages as necessary).

b. If **yes,** how long will the employee need the accommodation to perform their essential job functions? # of days # of weeks # of months or ☐ permanently