



Employee Travel 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:
<i>This form is solely for travel related accommodations. The information provided is an addendum to the Employee Accommodation Medical Statement Form that has been previously provided, without the requested travel accommodation information.</i>	

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 for travel. 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.



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

Yes No

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

3. **What** limitation(s) is (are) interfering with the employee's ability to travel?