UNIVERSITY OF ARKANSAS | Equal Opportunity, Compliance & Title IX

Reasonable Accommodation 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. I understand that this information may be provided to other appropriate parties to assist in determining appropriate accommodations. If non-university resources are determined to be appropriate, I understand that I will be notified and provide approval prior to information being shared.	
Employee Signature:	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 **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:		
Specialization/Type of Practice:		
Phone Number:	Fax Number:	
Business Address:		
City:	State:	Zip:
Physician Signature:	Date:	

Your patient is an employee of the University of Arkansas and has requested an accommodation. 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 **Office of Accommodation and Accessibility Services, 479.575.7637, or scan and email to** access@uark.edu.

1. Select the type of impairment the employee has: ☐ physical, ☐ mental, ☐ both, or ☐ the employee doesn't have an impairment

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a. If physical, mental, or both, please state the name of the impairment(s), diagnosis, or medical condition(s), including the ICD Code:

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

2. Is the impairment(s) (diagnosis) or medical condition(s) permanent? ☐ Yes ☐ No

   a. If **not** permanent, how long will the impairment(s) (diagnosis) or medical condition(s) likely last? # of days # of weeks # of months # of years

   b. Is this a condition(s) which may cause episodic rather than a continuing period of incapacity? ☐ Yes ☐ No

   c. Describe the employee's current symptoms:

   d. What are the employee's work limitations and/or restrictions?

   e. What is the planned course of treatment (include expected duration)?

   f. Is the employee taking medications or treatments that would be expected to affect job performance, 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

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

3. Does the condition(s) require periodic visits for treatment by a healthcare provider? ☐ Yes ☐ No

   g. Frequency of Visits:

   h. Date of most recent Visit:

4. Does the impairment(s) substantially limit a major life activity? ☐ Yes ☐ No

   a. Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the impairment(s) (diagnosis) or medical condition(s) or accompanying treatment.

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5. Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties and typical schedule.) What benefits of employment or essential job function(s) listed in the job description is the employee having trouble performing or accessing because of the limitation(s)?

6. Is the employee able to perform the essential functions in the job description provided with, or without, a reasonable accommodation?

   ☐ Yes, with a reasonable accommodation.

   ☐ Yes, without a reasonable accommodation.

   ☐ No, the employee is unable to perform their essential functions with or without a reasonable accommodation.

   a. If **no,** how long will the employee remain unable to perform their essential job functions?

      # of days # of weeks # of months or ☐ permanently

7. Do you have any suggestions regarding possible 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

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This section is only necessary if the Physician **DID NOT** answer question #4

Section 3: For Completion by the **HEALTHCARE PROVIDER** **Major Life Activities that are Affected**			
Organ System Affected	**Mild**	**Moderate**	**Severe**
Immune System			
Respiratory System			
Digestive System			
Endocrine System			
Circulatory System			
Nervous System			
Musculoskeletal			
Urinary System			
Physical Activity Affected	**Mild**	**Moderate**	**Severe**
Sitting			
Standing			
Walking			
Bending Over			
Climbing			
Kneeling			
Caring for Oneself			
Sleeping			
Breathing			
Speaking			
Eating			
Pushing and Pulling			
Lifting or Carrying: **10 lbs. or less**			
Lifting or Carrying: **11 to 25 lbs. or less**			
Lifting or Carrying: **26 to 50 lbs. or less**			
Lifting or Carrying: **51 to 75 lbs. or less**			
Lifting or Carrying:			

over 75 lbs.			

This section is only necessary if the Physician **DID NOT** answer question #4

Section 3: For Completion by the **HEALTHCARE PROVIDER** **Major Life Activities that are Affected**			
Physical Activity Affected	**Mild**	**Moderate**	**Severe**
Repetitive Use of Hands- Right Hand			
Repetitive Use of Hands- Left Hand			
Mental, Emotional, and Sensory Limitations	**Mild**	**Moderate**	**Severe**
Pace of Work			
Reasoning			
Manage Multiple Priorities			
Intense Customer Interaction			
Multiple Stimuli			
Frequent Change			
Short-Term Memory			
Long-Term Memory			
Attention Span			
Hearing			
Seeing			
Reading			
Analyzing			
Learning			
Written Communication			
Verbal Communication			
Interacting with others			
Other Major Life Activities that are Affected or Comments:			