UNIVERSITY OF ARKANSAS | Chancellor Equal Opportunity & Compliance

Travel 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 Equal Opportunity and Compliance, 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

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

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5. 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.

6. What is the Travel Accommodation Request pertaining to?
   - ☐ Assistance (equipment, etc.)
   - ☐ Lodging
   - ☐ Meals
   - ☐ Transportation

7. Please provide more details for what the request pertains to? (What is needed?):

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