



ARKANSAS SCHOOL

FOR MATH, SCIENCES, + THE ARTS

Reasonable Accommodation Medical Statement Form

Section 1: For Completion by the EMPLOYEE	
Name:	DOB:
Address:	City/State:
Job Title:	Email:
I authorize my medical provider(s) to complete this form for the purpose of exploring coverage and reasonable accommodations under the ASMSA Disability Accommodations Policy. I understand that this information may be provided to other appropriate parties to assist in determining appropriate accommodation. If non-school 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		
I attest that the individual name above is my patient. The information provided herein is based upon my knowledge of the patient's physical and/or mental impairment(s).		
Physician's Name:		
Specialization/Type of Practice:		
Business Address:		Phone number:
City:	State:	Zip:
Physician's Signature		Date:
Your patient is an employee of the Arkansas School for Mathematics, Sciences, and the Arts and has requested accommodation. To assist with the interactive process, we are requesting you to provide feedback on the following questions based on your medical expertise. Please answer questions on this form to help determine if there is a disability and potential reasonable accommodation(s) is needed. To expedite the processing of your patient's request for accommodation, please be as complete and specific as possible. Attach additional sheets as needed. For 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.		
When completed, please sign and either return to form to your patient, or scan and email to rievesn@asmsa.org .		

1. Select the type of impairment the employee has: physical mental both 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)				
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?? # of days # of weeks # of months # of year				
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 (including 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? Yes No 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
a. Frequency of visits: _____ b. Date of most recent visit: _____			
4. Does the impairment(s) substantially limit a major life activity?		Yes	No
a. Please describe the major life activity that are substantially limited by the impairment(s), diagnosis, or medical condition(s).			
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 work 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, reasonable accommodation? <div style="margin-left: 40px;"> Yes, with reasonable accommodation. Yes, without reasonable accommodation. No, the employee is unable to perform their essential functions with or without reasonable accommodation. </div>			
a. If no, how long will the employee remain unable to perform their essential job functions? <div style="display: flex; justify-content: space-around; margin-left: 40px;"> # of days # of weeks # of months or permanently </div>			
7. Is this a Service Animal Accommodation?		Yes	No
a. If yes, go to question 10			
8. 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? <i>(Please be specific, e.g., weight and time limits for mobility restrictions, functional features for office equipment, etc. (attach addition pages as necessary))</i>			

9. How long will the employee remain unable to perform the essential job functions?			
# of days	# of weeks	# of months or	permanently
10. Is the dog a service animal required for a disability? Yes No			
a. If yes, what task(s) or function(s) has the animal been trained to perform? (attach additional pages if necessary)			