CONFIDENTIAL

WORKPLACE ACCOMMODATION MEDICAL FORM

A. To be filled out by applicant or employee.

I authorize my medical provider(s) _____ to complete section B (below) based on information from my patient file and forward to the ADA Resource Center for Equity and Accessibility for the purpose of determining the appropriate job accommodations.

Signature: _____ Printed Name: _____ Date: _____

Medical Provider: To determine whether this employee is eligible under the Americans with Disabilities Act to request a workplace accommodation the University of Kansas ADA Resource Center for Equity and Accessibility requires verification of the employee's medical condition/ diagnosis and/ or disability. This form can be returned to the employee or faxed to (785)-864-5790. If you have any questions, please contact our office at 785-864-4946 or accessibility@ku.edu.

B. To be filled out by treating healthcare practitioner:

1. Please describe the employee's medical condition, diagnosis and/or disability:

   _____

   _____

2. How does the employee's medical condition, diagnosis and/or disability impact the individual?

   _____

   _____

3. Does the medical condition substantially limit one or more of the individual's major life activities? **(Yes or No)** **The impairment does not need to significantly or severely restrict the person's activities to meet the standard of being substantially limiting.*

   If yes, how?

   _____

   _____

4. What is the expected duration and frequency (if applicable) of the employee's medical condition, diagnosis and/or disability? If permanent, please indicate permanent.

   _____

5. Based upon the employee's medical condition, diagnosis and/or disability what workplace accommodation(s), are you recommending for this employee to be able to perform their job duties?

   _____

   a. Why are you recommending the above accommodation(s)?

      _____

      _____

   b. If the accommodation is for leave, what is the expected return to work date?

      _____

   c. If the suggested accommodation is not permanent, what is the likely duration of the accommodation? If permanent, state permanent.

d. If the suggested accommodation is for an Emotional Support Animal (ESA), how does the ESA mitigate the symptoms of the medical condition/disability?

_____

_____

d2. Is it necessary for the patient to live with their ESA in order to create equal enjoyment of their dwelling?

_____

_____

6. Could the employee's medical condition, diagnosis and/or disability be considered a direct threat to others or is the patient taking medications or treatments that would be expected to affect job performance, which would pose a direct threat or safety risk?
   Yes_____ No_____
   If yes, please explain _____

****COVID SPECIFIC QUESTIONS BELOW****

a. What is your medical recommendation regarding work accommodations for your patient to perform their job duties?

_____

b. If your medical recommendation is for your patient to telework during COVID-19 due to underlying health condition(s) mentioned in the above questions, please describe any accommodations that would permit your patient to work in-person. If none, please state none.

_____

<u>Please Sign before returning:</u>

Medical Provider Signature: _____Printed Name: _____

Medical Provider Phone Number: _____ Medical Provider Fax Number:_____

Medical Provider Address: _____ Date:_____

If you have questions about the legal terms of this form, please call 785-864-4946

Please fax this form to 785-864-5790, with CONFIDENTIAL: Attention <u>*The ADA Resource Center for Equity and Accessibility*</u> on the cover page.

The University of Kansas -1246 West Campus Road - Lawrence, KS, 66045