

**CONFIDENTIAL**

**WORKPLACE ACCOMMODATION MEDICAL FORM**

*A. To be filled out by applicant or employee.*

*I authorize my medical provider(s) \_\_\_\_\_ to fill out 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 \_\_\_\_\_*

*B. To be filled out by treating healthcare practitioner:*

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

\_\_\_\_\_  
\_\_\_\_\_

2. When did the medical condition(s) and/ or disability begin?

\_\_\_\_\_  
\_\_\_\_\_

3. How long is the condition expected to last? If the condition or disability is permanent, please indicate.

\_\_\_\_\_

4. Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, reading, bending communicating, sitting, interacting with others, etc.) or bodily functions (e.g., normal cell growth, digestive, neurological, musculoskeletal) that are substantially limited by the medical condition or accompanying treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

a. Please describe how these limitations impact the employee's ability to perform her/his job (please refer to employee's job description, if available):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. What accommodation(s), if any, would you recommend for this employee?

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

6. Could the 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? (See attached job description for statement of duties)  Yes  No

If yes, please explain

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Signed: \_\_\_\_\_ Printed name: \_\_\_\_\_

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 The ADA Resource Center for Equity and Accessibility on the cover page.**

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