THE UNIVERSITY OF ARIZONA
Disability Resource Center

DISABILITY RESOURCE CENTER

Highland Commons
1224 E Lowell Street
Tucson, AZ 85721

Main: 520-621-3268
Fax: 520-621-9423

http://drc.arizona.edu

# Medical Provider Form

## Employee Instructions

Please attach a copy of your accommodation request and job description, if available, to this form when you give it to your medical provider.

Employee Name: Phone:

Date of birth:

## Medical Provider Instructions

To determine whether this employee is eligible and needs accommodations, the University of Arizona's Disability Resource Center (DRC) requires documentation of their condition.
**Please write legibly or type the information** in the areas provided below.

Completed forms can be emailed to workplaceaccess@arizona.edu, faxed to (520) 621-9423 or returned to the employee. If you have any questions, please contact the DRC Workplace Access team at (520) 626-9559 or workplaceaccess@arizona.edu.

1) What is the employee's medical condition(s)?

2) How does this medical condition(s) impact or limit this individual?

3) What is the expected duration and frequency (if applicable) of the medical condition(s)?

4) Are this individual's major life activities or major bodily functions (e.g., seeing, hearing, walking, standing, lifting, bending, performing manual tasks, reading, communicating, concentrating, breathing, digesting, immune system, normal cell growth, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, etc.) impacted or limited by the medical condition(s)?
   Yes No
   a. If so, please list the major life activities or major bodily functions:

5) Are these limitations substantial in comparison to most people in the general population?
Yes No

6) What is the expected return to work date, if applicable?
**Note**: If an employee needs leave from their position, an estimated return to work date is required.
Date:

7) What is the impact of the medical condition or any related medications/therapies on the individual's ability to perform their job?
**Please be specific**, e.g., number of pounds unable to lift, distance unable to walk, period of time unable to stand or sit, frequency and length of breaks needed, amount of leave needed, etc.

8) If there are restrictions, what is the expected duration of the restrictions?

9) For faculty members requesting a tenure clock delay, how has the medical condition impacted the faculty member's ability to prepare for promotion and tenure?

---

Medical Provider Name: ____________________________________________________________

Medical Provider Signature: ________________________________ Date: ___________________

Medical Provider Phone Number: ________________________________________________________

Medical Provider Email Address: _______________________________________________________

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 employees or their family members. To comply with this law, we are asking 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.