MEDICAL STATEMENT FORM

Section 1: For completion by the EMPLOYEE	
Name:	
Job Title:	**Department:**
I authorize my medical provider(s) to complete this form for the purpose of Southwestern Oklahoma State University (SWOSU) exploring reasonable accommodations in the performance of my job functions.	
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 result of an individual 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).	
Healthcare Provider Name:	**Phone Number:**
Specialization/Type of Practice:	**Fax Number:**
Business Address:	
Your patient is an employee of SWOSU and has requested an accommodation. In order to assist with the interactive process, we are requesting you 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 exists. The following questions will help SWOSU in the review of this process.	
Does the employee have a physical or mental impairment? ☐ **Yes** ☐ **No** *If yes,* please state the name of the impairment(s) (diagnosis) or medical condition(s).	
Is this a condition(s) which may cause episodic rather than a continuing period of incapacity? ☐ **Yes** ☐ **No**	

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Is the impairment(s) (diagnosis) or medical condition(s) permanent?
☐ **Yes** ☐ **No**

If <u>not</u> permanent, how long will the impairment(s) (diagnosis) or medical condition(s) likely last?
_____ ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ Other - *please explain:*

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., coworkers, the general public, etc.)? ☐ Yes ☐ No
If yes, please explain the threat and any reasonable accommodation that would eliminate or reduce the threat to an acceptable level:

Does the impairment(s) substantially limit a major life activity? ☐ Yes ☐ No
If yes, 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.

Can the employee work from home (remote work)? ☐ Yes ☐ No

If the employee <u>cannot</u> work from home, please provide the estimated duration for the leave request:
Leave Beginning Date: _____ **Leave Ending date:** _____
If date is unknown, intermittent, or involves partial workdays, please provide further detail below:

If applicable, please explain how being granted leave as an accommodation will aide in the employee's ability to return to work.

Please provide any additional relevant information that you feel may be pertinent in our efforts to assist our employee.

Healthcare Provider Signature:	**Date:**

Once complete, please sign and either return the form to your patient,
or send directly to: SWOSU Human Resources Office, Fax: 580-774-6582 or Email: HR@swosu.edu
For questions regarding this form, please call SWOSU Human Resources at 580-774-3246