Arkansas Department of Finance and Administration

ADA Accommodation Form
Medical Professional Questionnaire

INSTRUCTIONS: The Arkansas Department of Finance and Administration (DFA) requests that as the treating medical professional of a DFA employee that you provide information to enable DFA to assess whether there is a reasonable accommodation that DFA can provide to permit the employee to perform the essential job functions of his/her job. The employee's essential job functions are attached.

Please return to DFA Human Resources by first-class mail marked CONFIDENTIAL:
Attn: DFA Human Resources, 1515 West 7th Street, Ste. 102
Little Rock, Arkansas 72203-2485
Or by fax to (501)683-2174.

If you have questions, please call the DFA Human Resources Office at (501)371-6009.

To be completed by employee's medical professional.

Patient/Employee's Name:

_____
First MI Last

Medical Professional's Name:

_____
First MI Last

Type of Practice: _____

Medical Specialty: _____

Business Address: _____
City State ZIP Code

Telephone Number: _____

Fax Number: _____

Medical Information

Please identify the medical condition(s) for which accommodations are required.

Dates of Treatment: _____

Probable Duration of Condition: _____

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Is Employee substantially limited in any major life activities as a result of his/her health condition? If so, please identify the major life activities.

Is Employee unable to perform any of the essential functions of his/her job as listed in the position description or limited in his/her ability to do so? If so, please identify each limitation or inability to perform and the expected duration.

Does the condition cause Employee any functional limitations (such as limitations in the ability to reach, stand, bend, grip, concentrate, speak, etc.)? If so, please describe the limitations and their expected duration.

Based upon your knowledge of Employee's condition, are there any accommodations that DFA can provide that you believe would permit Employee to perform the essential functions of his/her job?

Medical Professional Questionnaire (Continued)

Does Employee require leave from work or a reduced schedule as a result of his/her health condition? If so, please indicate what additional leave is required and/or what schedule of work Employee is able to adhere to and what you estimate to be the expected duration of this need.

Will the condition cause episodic flare ups periodically preventing Employee from performing his/her job functions? If so, please provide the anticipated frequency and duration of such flare ups as well as any accommodations that the employee will require as a result?

Please provide any additional information that you believe would assist DFA. Employee has been advised that this form must be fully completed by you. Please consult this document in completing this form. If you have any questions, please contact DFA Human Resources at 501.324-9065.

Medical Professional's Signature

Date

Printed Name

□ Please check here if additional information is attached to this form.