PROVIDER FORM

Medical Documentation of Disability for Special Consideration in Residence Life

To be completed by health care provider

Please send to **The Office of Student Accessibility Services**

Patient Name:_____
Date:_____

Diagnosis:_____ Date of
Diagnosis:_____

Date of last office
visit:_____

Level of severity: (Please Circle) Mild Moderate Severe
Medications:_____

Does medications(s) relieve symptoms?
_____

Please list side effects experienced by individual as related to current medications.

- A Disability is defined under the Americans with Disabilities Act as "a physical or mental impairment which substantially limits a major life activity"

Based on the above definition of disability, do you feel that this individual exhibits a substantial limitation in a major life activity (ies)? ____Yes ____No

Please list major life activities which are limited and link to functional limitations.

Major Life Activity Functional Limitation

_____

Major Life Activity Functional Limitation

What is the expected duration of impairment? _____
Please discuss expected long term effects of
condition._____
_____
_____
How many days/months did the impairment limit major life activities during the past year?
_____
Last hospitalization for condition _____
Last exacerbation of condition _____
What accommodations, as linked to functional limitations, are recommended to support this individual in residential living?

Functional Living Recommended Accommodation (please provide alternative accommodations if applicable)

Role recommended accommodation will play in treatment plan
_____
_____

Why is this accommodation necessary and how will it impact the student's ability to live in the residence hall? (With respect to Air Conditioning, please be specific and detailed as to how AC will limit the student's behavior and be harmful without.)
_____
_____

In certain instances, Student Accessibility Services needs to contact the provider regarding accommodations. If this applies to the above mentioned student, we will contact you. Thank you.
Please provided the following personal information and attach any additional information which may be helpful in determining eligibility accommodations. Thank you.
Print Name and Title _____
Area of Specialty _____
License # _____
Address: _____
Telephone _____ Fax _____
Signature _____ Date _____
Please note that all information is confidential and is for the use of University staff