# Medical Provider Documentation Form

Medical/Health Care Provider Completes and Signs Sections Below

Student's Name _____ Date:_____

To consider this student's request for accommodations due to a disability/chronic condition/mental health condition which limits one or more of the major life activities, we require documentation of the student's current condition from the treating and licensed clinical professional or medical healthcare provider. All documentation submitted is deemed confidential.

Items should be completed in full. If more space is needed, please attach a separate sheet of paper.

Student's disability/diagnosis: _____

The code for this is_____ from the DSM-IV-TR ☐ DSM-V ☐ ICD-9 ☐ ICD-10 ☐

When was the condition first diagnosed? _____

_____

When was the student last seen by you? _____

How often do you see this student: Weekly ☐ Monthly ☐ Every 3-6 Months ☐ Yearly ☐

How did you arrive at your diagnosis? Check all that apply below:

Structured or Unstructured Interviews ☐ Medical Tests ☐

Interviews with Other Persons ☐ Medical History ☐

Behavioral Observations ☐ Developmental History

Psychoeducational and/or Psychological Testing

***Please attach testing reports/results of the current diagnosis you are reporting. Please do not diagnose disabilities outside of your licensed specialty (i.e., licensed social worker diagnosing eye diseases).***

Does the student's disability/condition significantly limit any major life activity? If yes, please describe the limitation or restriction.

_____

_____

_____

Please check the current **functional limitations or behavioral manifestations** for this student:

| | Not An Issue | Moderate Issue | Substantial Issue | Do Not Know |
|---|---|---|---|---|
| Cognitive Processing | | | | |
| Memory | | | | |
| Processing Speed | | | | |
| Meeting Deadlines | | | | |
| Organization | | | | |
| Time Management | | | | |
| Focus | | | | |
| Reasoning | | | | |
| Anxiety/Stress | | | | |
| Sleep | | | | |
| Other: | | | | |

Please note any assistive devices/services currently in use_____

_____

_____

Please note any medications currently prescribed_____

_____

Will the medications adversely affect the student? If so, how?

_____

_____

Please state specific recommendations regarding the accommodation(s) this student needs in a post-secondary education course and program.

_____

_____

_____

_____

_____

_____

For how long do you consider the disability/condition to be valid without reassessment and/or updated information?

[ ] The circumstances described in this form are **permanent and stationary.**

[ ] The circumstance described in this form may not be permanent or stationary, but I expect no significant change through _____, _____

Month Year

**Please fill in all fields below:**

**Signature of Provider**

_____ Date_____

License # and/or other professional credentials:

_____

_____

Print Name and Title

_____

Address

_____

_____

Phone

_____

Fax

_____

**Students: Please upload this form when completed into the Accommodate portal. Do not email the form. Thank you.**

**Contact Information:**

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