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)

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

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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_______________________________________

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Please note any medications currently prescribed____

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

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

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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

____

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Phone

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Fax

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