Americans with Disabilities Accommodations (ADA) Medical Provider’s Form

A patient/client of yours has requested disability-related services from Ottawa University. Legal protection and eligibility for such services is based on the individual providing sufficient information to conclude that he or she has an impairment that substantially limits one of more major life activities, including the ability to make satisfactory academic progress in a college or university setting. As this individual’s treating specialist, you are asked to provide the following information to assist the university in considering this student’s accommodations request.

1. Patient/Client Name: __________________________________________________________________________

2. DOB: ______________ Last Four Numbers of Social Security Number ________________________________

3. What is (are) the diagnosis/impairment? (Please write this out rather than simply indicating the ICD or DSM code): __________________________________________________________________________

4. When was the diagnosis originally made? __________________________________________

5. Is the patient/client currently receiving your services? ______ If so, how often? ________________

6. When did you last see the patient/client? _______________________________________________

7. Is the impairment temporary (<3 months) or persistent? ________________________________

8. Please identify any factors that may affect the severity of the impairment (e.g., compliance with medications, hearing aids, back brace, stress levels, etc.)
   ______________________________________________________________________________________
   ______________________________________________________________________________________

9. If there might be adverse side effects to medications, that would substantially impair the individual’s ability to make satisfactory academic progress, please describe:
   ______________________________________________________________________________________

10. Which of the following limitations might substantially affect the patient’s/client’s ability to function effectively in a college or university environment? (Check all that apply):
    _____ talking  _____ listening  _____ sitting  _____ seeing
    _____ reading  _____ writing  _____ spelling  _____ concentrating
    _____ memorizing  _____ sustaining attention  _____ completing work by a deadline
    _____ using a computer  _____ regularly attending class  _____ following instructions
11. Please identify any additional functional limitations that might affect academic performance:

________________________________________________________________________

________________________________________________________________________

12. What method(s) were used to assess functional limitations of performance in an academic environment? (e.g., interview, tests, observations, etc.)

________________________________________________________________________

________________________________________________________________________

13. Please indicate your recommendations for accommodations. Please keep in mind that the impairment(s) must substantially affect the individual’s ability to maintain satisfactory academic progress in a college or university setting.

____ large print books and/or Braille
____ audio taping class sessions
____ sitting toward the front of the room
____ providing instructions in advance
____ opportunities to make up class sessions if hospitalized or evidence provided by health care professional that class attendance was impossible or not recommended
____ extra time (extensions) to complete assignments
____ additional guidance for following directions for assignments
____ other (please specify): ________________________________________________________________________

Certifier Information

Clinician Name (please print): ________________________________________________

Type of Professional License (e.g., MD, psychologist, LNP, MSW, etc): ______________

Address: __________________________________________________________________

Phone: ___________________________ Email: ________________________________

Signature: ____________________________________________________________ Date: ______________

Please return the completed form to:

Attn: Disabilities Services Coordinator: ________________________________________

Fax: ______________________________________________________________________

Email: ________________________@ottawa.edu

Phone: _____________________________

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