Susquehanna UNIVERSITY
Disability Services

MEDICAL PROVIDER FORM

Susquehanna University is committed to the full participation of students with disabilities in all aspects of college life. This form, along with medical documentation, will help Disability Services determine this student's eligibility for accommodations. It is to be completed by a licensed physician or other qualified healthcare provider with experience and expertise regarding the functional limitations of the student's disability, current symptomology, and potential impact on the student's participation in the academic environment.
The health care professional completing this form must be an impartial individual who is not a family member of the student.

To be Completed by the Student:

Name: _____ Birthdate: _____

Campus Address: _____ Email: _____

Cell Phone: _____

Home Address: _____

Graduation Year: _____

To be Completed by the Medical Professional/Medical Provider:

Name: _____ Professional Title: _____

License/Certification Number & State: _____

Highest Degree: _____

Address: _____

Phone: _____ Email: _____

*Date of First Contact: _____ *Date of Last Contact: _____

The student named above has requested disability-based accommodations at Susquehanna University. A disability is defined under the Americans with Disabilities Act as “a physical or mental impairment that substantially limits one or more major life activities.” Examples of major life activities are listed in Item 4. A temporary impairment may include an injury, severe illness, recovery from surgery, or a condition caused by a traumatic event.

1. Under the ADA, this individual has a …. (*Please select one*)

□ Disability □ Temporary Impairment

Diagnosis	Diagnostic Code from:	Does this disability or impairment substantially limit a major life activity?	Please rate this disability or impairment	Please describe this disability or impairment
	□ DSM-IV-TR □ DSM-V □ ICD-9 □ ICD-10	□ Yes □ No □ When Active	□ Mild □ Moderate □ Severe	□ Stable □ Variable □ Progressive
	□ DSM-IV-TR □ DSM-V □ ICD-9 □ ICD-10	□ Yes □ No □ When Active	□ Mild □ Moderate □ Severe	□ Stable □ Variable □ Progressive
	□ DSM-IV-TR □ DSM-V □ ICD-9 □ ICD-10	□ Yes □ No □ When Active	□ Mild □ Moderate □ Severe	□ Stable □ Variable □ Progressive

1. How was this diagnosis made? (For example, what form of assessment did you reply upon?)

2. Please describe **in detail** the limitations of the disability.

3. Please check the major life activity or activities that are substantially limited by the disability/impairment:

□ bending	□ lifting	□ standing
□ breathing	□ manual tasks	□ thinking
□ communicating	□ reading	□ walking
□ concentration	□ seeing	□ working
□ eating	□ self-care	□ speaking
□ hearing	□ sleeping	
□ learning	□ the operation of major bodily functions	
□ other: _____		

(If Requesting Dietary Accommodations Only, Skip to Question 9 and Complete Questions 9-13)

4. Please describe **in detail** how the disability interferes with one or more of the major life activities as would be encountered in the academic environment.

5. Please explain **in detail** the symptoms currently experienced by the student.

6. Please indicate **in detail,** based on the student's condition, what *specific recommendations* you suggest for this student, so they have equal, appropriate, and reasonable access to services and programs.

7. Academic Accommodations for this condition are recommended:

   □ for several months; How many? _____

   □ for the next year

   □ for the duration of the student's time in college

   □ other comments:

   I have attached supporting documentation for this diagnosis (see Documentation Guidelines) I confirm the validity of all information and attest that I am not related to this student.

Signature of the Professional: _____ Date: _____

Dietary Accommodation Requests

Susquehanna University is a four-year residential college and all students living on campus are required to purchase a meal plan. **Students in need of dietary modifications should not expect exemption from this meal plan requirement**. University Dining Services makes every effort to meet individual dietary needs.

9. Does the student have an identified disability that requires him/her to have a special diet?

□ Yes □ No

If yes, please explain:

10. The student is allergic to:

□ milk
□ wheat
□ soy
□ peanuts
□ tree nuts
□ fish
□ shellfish
□ whole eggs
□ egg as an ingredient
□ gluten
□ other (please be specific)

11. Triggered by: Contact ____ Ingestion ____ Airborne ____ Inhalation____

12. Using as much space as needed, please describe the type, severity, and frequency of symptoms currently experienced by the student, and how the disability interferes with eating or dining in college facilities.

13. Accommodations for this condition are recommended:

- □ for several months; How many? _____
- □ for the next year
- □ for the duration of the student's time in college
- □ other comments:

I have attached supporting documentation for this diagnosis (see Documentation Guidelines) I confirm the validity of all information and attest that I am not related to this student.

Signature of the Professional: _____ Date: _____