MONMOUTH UNIVERSITY | DISABILITY SERVICES *for* STUDENTS

Disability Provider Information Form
-Academic Documentation-

Form cannot be completed by relative of client/patient.

You are being asked to provide documentation of disability for:_____.
Client/Patient Name

Please fill out the form below and attach the appropriate supplemental documentation. Thank you in advance for your support and cooperation in this matter.

Practitioner Name/Title _____Date_____

Address_____

Telephone _____ FAX _____

License or Certification number_____

Specialty/qualification to make diagnosis_____

Date of last appointment_____

To be eligible for services, your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. "Major life activities" are functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, reproduction, and working.

1. Nature of disability with formal diagnosis. Please include expected duration.

Diagnosis	Date of Diagnosis	Date of last contact	Expected duration
Comments:			

2. Describe the symptoms associated with the condition _____

_____

_____

3. Severity of condition. ☐ MILD ☐ MODERATE ☐ SEVERE

4. Check all relevant functional limitations that are substantially limited.

_____Walking _____Hearing _____Seeing _____Working _____Sleeping _____Caring for self

_____Interacting with others _____Learning (including memory/concentration)

_____Performing manual tasks _____Other, please describe _____

5. List current medication(s), dosage, frequency and adverse side effects.

Medication	Dosage	Frequency	Side Effects:

6. Please explain how each functional limitation will specifically affect your client/patient in the academic environment.

_____

_____

_____

7. **PLEASE SUGGEST REASONABLE ACADEMIC ACCOMMODATIONS**. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation.

_____

_____

_____

8. Please state alternatives to meet the documented need if the first request cannot be met.

_____

_____

_____

9. Please discuss the impact on your client/patient's disability if the accommodation cannot be granted.

_____

_____

_____

10. Additional comments:

_____

_____

By signing this Disability Provider Information Form, I verify and acknowledge that I am the treating professional of the student and that the information provided herein is accurate. I further verify and acknowledge that I am not a relative of the student.

Signature of Specialist Date 19

Please note that the Director of Disability Services for Students in consultation with appropriate school officials will make all final decisions on which accommodations will be granted.

Please return the completed form and supplemental documentation to:

The Department of Disability Services for Students Monmouth University
400 Cedar Avenue West Long Branch, NJ 07764
732-571-3460 ☎ 732-263-5126 🖷 dds@monmouth.edu