MONMOUTH UNIVERSITY | DISABILITY SERVICES *for* STUDENTS

Request for Academic Accommodations Provider Form

This form must be completed by a licensed professional.

You are being asked to provide documentation of a diagnosis for: _____

[Client/Patient Name]

Practitioner Name/Title: _____

License or Certification number: _____

Specialty/qualification to make diagnosis: _____

Please place licensed healthcare professional's stamp.
If treating healthcare professional does not have a stamp, Submitting letterhead will be accepted in its place.
If left blank, form will not be accepted.

The healthcare provider completing this form cannot be a relative of the student.

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:

_____

_____

My signature verifies that I am the treating healthcare professional and that the contents of this form are accurate.
The healthcare provider completing this form cannot be a relative of the student.

Signature: _____ Date: _____

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.

Email Print

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