

Request for Academic Accommodations Provider Form
This form must be completed by a licensed professional.

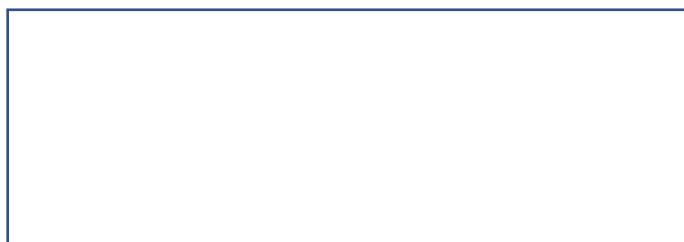
You are being asked to provide documentation of a diagnosis for: _____
[Client/Patient Name]

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 _____

DDS Academic Provider Information Form

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.

**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**