MONMOUTH UNIVERSITY | DISABILITY SERVICES *for* STUDENTS

Disability Provider Information Form
-Meal Plan 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: _____

License or Certification number: _____

Specialty/qualification to make diagnosis: _____

Date of last appointment_____

Please place licensed healthcare professional's stamp.
If treating healthcare professional does not have a stamp, Submitting letterhead or digital signature at end of form will be accepted in its place.
If not complete, form will not be accepted.

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. Severity of condition. ☐ MILD ☐ MODERATE ☐ SEVERE

3. 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 ☐ Eating ☐ Other, please describe_____

4. Please explain how each functional limitation will specifically affect your client's ability to partake in the University Meal Plan.

_____

_____

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

Medication	Dosage	Frequency	Side Effects:

5. Please list all foods/ingredients that your client is unable to eat and a **RAST rating for each**. Please explain specifically why each type of food cannot be eaten and whether or not patient uses an EpiPen.

Food	RAST Rating	EpiPen
		☐ Yes ☐ No
Comments:		

6. Please suggest reasonable accommodations and/or modifications to the University Meal Plan. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation.

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

9. Additional comments:

_____

_____

_____

Please note: All final decisions on which reasonable accommodations will be granted are made in consultation with the Department of Disability Services for Students, Gourmet Dining, LLC (food service provider), Office of Residential Life, and other offices as needed on a case-by-case basis. **At no time is a change in meal plan or removal from the meal plan guaranteed.**

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

Print Email

Please return the completed form and supplemental documentation to:

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