UNIVERSITY OF ST. AUGUSTINE
FOR HEALTH SCIENCES

Treatment Provider Verification of Disability Form

Medical Provider: This student is requesting accommodations from the University of St. Augustine for Health Sciences based on disability. The University, for the purposes of establishing reasonable accommodations, requires current information about the nature of the student's condition. The information submitted will be reviewed on a case-by-case basis specifically looking at the impact of the condition on this individual and within the specific context of the requested accommodations.

Student Name: _____ Date of Birth: _____

Provider Name: _____ Phone Number: _____

Mailing Address: _____

License or Certification #: _____ Credentials/Area of Specialty: _____

Email:_____

1.) Is the above-named student currently under your care? Yes No

2.) What is the date of your last clinical contact with the student? _____

3.) What condition/s are you currently treating the individual for? _____

_____

4.) Please indicate the extent to which the condition currently impacts this individual and how it could impact their academic experience, didactic and clinical setting if appropriate. Please include duration of impact, severity of condition and any additional information you deem appropriate for us to consider.

5.) What accommodations do you recommend for this student?

6.) Please provide any additional information you believe is pertinent to our consideration of the student's accommodation request.

Provider Signature: _____ Date: _____