UNIVERSITY of ST. AUGUSTINE for HEALTH SCIENCES

Treatment Provider Verification of Disability

The student listed below is seeking accommodations at the University of St. Augustine for Health Sciences based on disability. In order to establish eligibility, the student must provide current, comprehensive documentation that establishes the condition/s and their impact on the student's ability to perform the essential functions of their program of study.

By completing this form, you are certifying that in your professional opinion, the student qualifies as a person with a disability under the Americans with Disabilities Amendments Act (ADAAA).

INSTRUCTIONS: This form should be completed as thoroughly as possible, by an appropriately licensed professional that has conducted the assessment, made the diagnosis, or is currently treating the student. Attach additional pages as needed.

Student Information:

Student Name: _____ Date of Birth: _____

Disability Status:

1.) In your professional judgment, does this individual have a disability? Yes ☐ No ☐

The legal definition of disability is a mental or physical condition lasting 6 months or longer, that substantially limits a major life activity compared to most people. Substantial in this context is somewhat subjective but means a notable, significant, or meaningful limit/difference to the manner in which the individual engages in the activity, the conditions necessary for them to engage in the activity, the duration for which they can engage in the activity or the frequency which they can engage in the activity. Major life activities can include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, sleeping, walking, breathing, learning, concentrating, thinking, communicating, working, stress management and the proper functioning of major bodily systems (digestion, pituitary, endocrine).

2.) If yes, please indicate the condition/s that qualify as a disability. _____
_____
_____

3.) Date of diagnosis: _____

4.) How long has the individual been under your care? From _____ to _____

5.) Please list current symptoms of the indicated condition/s that are relevant to the student's request for accommodation. _____
_____
_____

Duration, Severity, Impact:

6.) What is the expected duration of this disability?

- ☐ Permanent
- ☐ Temporary, indicate the anticipated duration: _____
- ☐ Unknown, describe: _____

7.) What is the prognosis of the condition?

- ☐ Active
- ☐ Controlled
- ☐ Progressing
- ☐ In remission

8.) What is the severity of the symptoms?

- ☐ Mild
- ☐ Moderate
- ☐ Severe

Major Life Activities:

Answer the following question based on what limitations the individual has when the condition is in an active state and what limitations the student would have without regard to the ameliorative effects of any mitigating measures. Mitigating measures include, but are not limited to, things such as medication, medical supplies, equipment, hearing aids, mobility devices, assistive technology, auxiliary aids or services, prosthetics, etc.

9.) Does the impairment substantially limit a major life activity as compared to most people in the general population? Yes ☐ No ☐

10.) If yes, what major life activity(s) is/are affected?

Bending	Hearing	Sitting
Breathing	Learning	Speaking
Caring for Self	Lifting ____ lbs.	Sleeping
Communicating	Performing Manual Tasks	Standing
Concentrating	Reading	Thinking
Eating	Seeing	Walking

Other/s: please describe: _____
_____
_____

11.) Does the student have physical restrictions (i.e. lifting, sit/stand, gait, balance, dexterity, mobility, push/pull)?
Yes ☐ No ☐

If Yes, please complete the following:

11a.) Provide specific information about the restrictions for each area of impact such as threshold limits in lbs., range of motion, duration of sit/stand, etc. _____
_____
_____
_____
_____
_____
_____

11b.) For PT, OT and SLP only: Provide specific recommendations for the academic program that will allow the student to meet the essential functions of their program of study (i.e. assistive devices, modification of tasks). A list of the essential functions is available upon student request.

12.) Please describe the impact on major bodily functions, if any, (i.e. immune, endocrine, respiratory, neurological, digestive, etc.) _____
_____
_____
_____

13.) Please state your specific accommodation recommendations and rationale based on the student's functional limitations. _____
_____
_____
_____
_____
_____

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

Provider Information:

Provider Signature: _____ Signature Date: _____

Provider Name and Title: _____

Credentials/Area of Specialty: _____

Physical Address:

Phone Number: _____

State of License: _____ License Number: _____