Ursinus COLLEGE | OFFICE OF DISABILITY AND ACCESS

URSINUS COLLEGE ACCOMMODATION REQUEST FORM FOR HEALTH CARE PROVIDERS

Student name:_____ Student email:_____

Student ID number:_____ Student phone:_____

Instructions for Treating Professional

This evaluation should be filled out by a qualified, treating health care professional. Your name, signature, title, and credentials should be provided on this form. The student has been informed and agrees that the accommodation request process asks the treating professional to document the medical necessity of the requested supports. This request for documentation complies with ADAAA (Americans with Disabilities Act Amendments Act).

Please forward this completed form and any other supporting documentation to:

Office of Disability and Access
Ursinus College
601 E Main Street
Collegeville, PA 19426
Email: disabilityandaccess@ursinus.edu

Treating Professional Information

Name:_____ Title:_____

Practice:_____ License/Certification Number:_____

Phone:_____ Email (optional):_____

Federal laws define a person with a disability as "any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment." Please answer the questions on the next page to provide more information about the student's diagnosed condition that rises to the level of a disability.

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What is/are the student's current diagnosis/diagnoses?

What are the functional impacts of the diagnosis/diagnoses?

How does the student's diagnosis/diagnoses impact their life on campus? Academically? Residentially?

What accommodations do you recommend to help the student access the college experience?

How do the recommended accommodations address the student's functional impacts?

Please note: Section 1001 of Title 18 of the United States Code makes it a criminal offense to willfully falsify a material fact or make a false statement in any matter within the jurisdiction of a federal agency.

_____ _____

Signature of treating professional Date