Disability Provider Information Form

Please fill out the form below and attach appropriate supplemental documentation for your client, _____. Thank you in advance for your support and cooperation.

Practitioner Name/Title _____ Date_____

Address_____

Telephone _____ FAX _____

Specialty/qualification to make diagnosis _____

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, sleeping, learning, caring for one's self, performing manual tasks, reproduction, and working.

1. Diagnosis, instruments and procedures for diagnosis, date of diagnosis and date of last contact with student. Please include expected duration.
   _____
   _____
   _____
   _____

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 _____

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

6. Please explain how each functional limitation will specifically affect your client in the academic environment.

_____

_____

_____

7. Please suggest reasonable 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's disability if the accommodation cannot be granted.

_____

_____

_____

10. Additional comments:

_____

_____

_____

Signature of Specialist Date

Please note that the office of Accessibility Services and Accommodations staff, in consultation with appropriate University officials, will make all final decisions on which accommodations will be granted.

Please return the completed form and supplemental documentation to:
Office of Accessibility Services and Accommodations
St. Bonaventure University
P.O. Box 2479
St. Bonaventure, NY 14778
Fax: (716) 375-2072
E-Mail: asa@sbu.edu