PROVIDER QUESTIONNAIRE FOR REASONABLE ACCOMMODATION REQUEST

Student Name: ________________________

TO BE COMPLETED BY STUDENT'S EVALUATION / TREATMENT PROVIDER

Please state your general area of practice (e.g., Internal Medicine, Family Practice, Psychology, etc.) and any specialty within your practice area:

1. Have you evaluated or treated the Student for the Condition for which an accommodation is requested?

   Yes _____ No _____

   If "Yes:"

   a. Diagnosis:

   b. Date diagnosed:

   c. Approximately when did the Condition begin?

   d. Last date you examined or treated the Student for the Condition:

   e. All other dates in the past 12 months that you examined or treated the Student for the Condition:

   f. What treatment have you provided to the Student for the Condition in the past 12 months?

   g. What is the Student's current treatment plan (describe in detail)?

h. Prognosis:

i. Is the Condition temporary or permanent?

________Temporary ________Permanent

If "Temporary," approximately how long will it last?

j. How often is the Student to see you?

2. List all dates of upcoming appointments that have already been scheduled:

3. Does the Condition in question limit the Student's ability to fully participate in an academic program, complete coursework, or perform essential daily functions?

________Yes ________ No

Describe how the Condition in question limits the Student:

4. In addition to the above, the Student has the following restrictions:

5. List all measures or steps you have recommended to the Student could be used to address the limitations or restrictions that are caused by the Condition:

6. List any other suggestions you may have on how we may be able to accommodate the Student's restrictions caused by the Condition in a manner that would be effective and enable him/her to perform all academic responsibilities.

If there is any additional information which you believe would be helpful to us in evaluating the Student's request for a reasonable accommodation, please attach a separate page with the information.

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I have reviewed the above information and state that it is true and accurate to the best of my knowledge and belief.

Signature of Provider:___________________________________Date: ___________________

Printed Name: ____

Name of Practice: ____

Address: ____

Phone:_______________________________Fax:

Email: