STUDENT ACCOMMODATION VERIFICATION FORM

Health Care Provider Statement

The student identified below has declared a disability and requested accommodation(s) at the University of Tulsa under the provisions of the Americans with Disabilities Act (ADA). The attached form is to be completed by the health care provider and should be submitted to The University of Tulsa Compliance Office with the student’s Reasonable Accommodation Request Form. The information requested is for the following reasons:

- To determine if the individual meets the ADA definition of “individual with a disability”
- To determine if the individual is a qualified person under the ADA, meaning an individual with a disability who, with or without reasonable accommodation, can fulfill the essential functions and requirements of the program or activity without posing a direct threat to the health and safety of themselves or others
- To identify an effective reasonable accommodation to help mitigate the individual’s functional limitations and/or provide equal access related to the institution’s programs and activities

The Americans with Disabilities Act and Amendments (ADA-AA) defines disability as “a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment.” Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

The responsibility of making accommodation decisions or deciding whether or not it is possible to make a reasonable accommodation for a person with a disability lies with officials of The University of Tulsa. Documentation required to verify the student’s condition and its severity includes completion of this form or provision of equivalent information to the University of Tulsa by a professional with the appropriate training and credentials. Depending on the student’s condition, the appropriate professional should be a licensed psychiatrist, psychologist, medical doctor, licensed counselor, or other qualified and licensed health professional. Any professional completing this form must have first-hand knowledge of the student’s condition, experience in working with people with disabilities and a familiarity with the physical, emotional and cognitive demands experienced by students in a collegiate setting. Documentation should include information that describes the condition, the functional difficulties and limitations for the collegiate setting, indicates the severity and longevity of the condition(s), and offers recommendations for accommodation. Diagnoses of disabilities documented by family members are unacceptable. For additional information regarding documentation guidelines, refer to the Educational Testing Services (ETS) guidelines at www.ets.org.

For the Student: Medical Authorization

I, __________________________ (print name), do hereby authorize my health care provider to furnish and communicate with The University of Tulsa all medical information pertaining to my request for reasonable accommodation(s). My student ID number is: _____________.

Student Signature          Date
Section II: Physician’s Section

In addition to the diagnostic report/testing, please attach other information relevant to this student in the collegiate setting that will aid in making appropriate decisions about accommodations.

Today’s Date: ____________________  Please attach your business card.
Print Name: __________________________________________________________
Title: ________________________________________________________________
Signature: ____________________________________________________________

Signature denotes: content accuracy, adherence to professional standards and guidelines on page 1 of this document. By my signature I affirm that all statements and documents that I am submitting in support of a request for reasonable accommodation are true and correct. I understand that falsifying or misrepresenting facts or information may result in violation of professional standards or the law.

License Type: _________________________  License Number: _________________________
State: __________________  Expiration Date: __________________
Mailing Address: _____________________________________  City/State/Zip: ________________
Phone: (________) ____________  Fax: (________) _____________  Email: _______________________

Diagnostic Information

Diagnosis(es):                                                                 Date of Onset:

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

Date of student’s last appointment with you: __________________

How often do you see the student for care?  weekly  monthly  twice monthly  annually  as needed

Diagnostic Tools

How did you arrive at your diagnosis/diagnoses? Please circle any relevant items below:

Interviews with the employee  Behavioral observations  Interviews with other persons
Interviewer-rated scales  Self-rated scales  Medical history  Developmental history
Please attach or summarize any administered diagnostic testing, psychological testing, neuropsychological testing, etc., including the names of any testing instruments used:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Medication/Treatment/Prescribed Aids

1. Are any relevant treatments, medications, and/or prescribed aids currently being used for the diagnoses above? Please describe any impact this may have on performing essential job functions.

2. Describe any other relevant aspects of this condition and functional limitations that may impact fulfilling essential functions and requirements.

3. Does this student continue to need the above services, treatment, or medications when utilizing any recommended accommodations? Circle: Yes  No

4. What recommendations do you make regarding effective academic accommodations to equalize this student’s educational opportunities at the post-secondary level? (Describe services/accommodations in exam administration, classroom or study activities, course requirements, transportation or adjustment of the classroom physical environment.)

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

In addition to the diagnostic report/testing, please attach any other information relevant to this student’s academic adjustment that will aid in making appropriate decisions about accommodations.

Please return completed form to Student Access (contact info page 1): ATTN: Dave Kobel, Director.