ACADEMIC SERVICES
OFFICE OF ACCESSIBILITY SERVICES
Beneficial-Hodson Library & Learning Commons, Suite 1027 Contact: 301-696-3569
AccessibilityServices@Hood.edu

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROFESSIONAL

A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities." Examples of major life activities are: seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, thinking, concentrating, learning, reading, communicating, working, performing manual tasks, caring for oneself, and the operation of major bodily functions. A temporary impairment may include an injury, severe illness, recovery from surgery, or a condition caused by a traumatic event.

STUDENT NAME:_____ **DATE OF BIRTH:**____/____/____

CARE PROVIDER INFORMATION:

PROVIDER NAME:	**CREDENTIALS / LICENSING**
PROVIDER PRACTICE NAME & ADDRESS (OFFICE STAMP ACCEPTABLE)	
OFFICE PHONE NUMBER:	**OFFICE EMAIL:**

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Your patient/client has requested academic accommodations through the Office of Accessibility Services at Hood College. In order to provide reasonable accommodations, we require documentation of the specific functional limitations that result from the individual's disability. General statements about the disability do not help determine appropriate accommodations. Understanding the functional limitations of the disability allows us to understand the degree to which the disability substantially interferes with the academic environment for our student.

We require clear documentation of limitations in function or performance specifically as it relates to the academic setting. Substantiated need is constituted by a severe or chronic disabling condition that has been well-documented by an appropriate, qualified professional.

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The healthcare professional completing this form must be actively treating the student for the disability that can impact the student's academic experience. The form may not be completed by a family member, friend or office manager or staff. **Hood College Health Services can complete this form when the request is temporary (e.g. needed for under 30 days.)**

Is this considered a temporary disability? (e.g. short duration of time such as less than 6 months, needing recovery from surgery, etc.)

_____No, this is not considered a temporary disability.

_____Temporary; If temporary, the anticipated duration of the condition is:

- Less than 30 days
- One semester
- One academic year (two semesters)
- Other:_____.

Note: Under ADA, chronic conditions can qualify as disabilities even when they are not active. A condition that causes periodic flare-ups (such as Crohn's disease) will qualify as a disability if it meets the definition in its active state. Similarly, a person whose cancer is in remission will qualify as having a disability if that condition, when active, would meet the definition.

Must be completed by the treating medical provider:

Diagnosis:	**Diagnostic code:**	**Date of Initial Diagnosis:**	**Diagnosis Made by You: (yes/no)**	**For this diagnosis, are you currently seeing this student on a scheduled basis? (Select one or explain other)**
Dx #1:				Weekly Monthly Annually As needed Ended treatment Other:
For DX 1: Is the medical condition:_____Acute_____Chronic_____Episodic *Please explain:* Level of severity: mild moderate severe				
Dx #2:				Weekly Monthly Annually As needed Ended treatment Other:
For DX 2: Is the medical condition:_____Acute_____Chronic_____Episodic *Please explain:* Level of severity: mild moderate severe				
Dx #3:				Weekly Monthly Annually As needed Ended treatment Other:
For DX 3: Is the medical condition:_____Acute_____Chronic_____Episodic *Please explain:* Level of severity: mild moderate severe				

Date of most recent evaluation:_____/____/____

Currently under your care:_____Yes _____No, ended on:____/____/____

a. Does the patient take any medications?
b. ____Yes ____No _____When necessary

c. Additional comments, if necessary

_____

_____

What potential side effects are associated with the medication(s) listed above?

_____

_____

Medical or therapeutic equipment needed (This would **not** be provided by Hood College but needs to be accommodated within the classroom environment.)

_____

_____

_____

_____

_____

_____

Please indicate whether and how this student may be at risk during an emergency evacuation of the residence hall (e.g. fire):

_____

_____

_____

_____

_____

_____

_____

Please check which of the major life activities listed below are affected because of the medical diagnosis. Please indicate the level of limitation.

Life Activity	No Impact	Moderate Impact	Substantial Impact	Don't Know
Concentrating	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Self-care	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐
Timely submission of assignments	☐	☐	☐	☐
Attending class regularly and on time	☐	☐	☐	☐
Making and keeping appointments	☐	☐	☐	☐
Stress management	☐	☐	☐	☐
Organization	☐	☐	☐	☐

OTHER:

_____

_____

_____

Academic Accommodation Recommendations: (check all that apply and feel free to add notes)

***These are to be considered recommendations and must be reviewed along with required psychological assessments or medical reports, and if necessary, modified by Accessibility Services office before added to an accommodation plan. ***

Recommended Reasonable Academic Accommodations:

_____
_____
_____
_____
_____
_____

As a result of the aforementioned medical condition, the impact on the patient in terms of doing college level work is such that he/she will be:

⎦ Totally Incapacitated and should:

____ Withdraw from college at this time.

____ Take a medical leave of absence.

____ Other (please specify) _____

_____

_____

⎦ Partially Incapacitated and has been advised to:

____ Reduce his/her academic course load (please be specific)

____ Other (please specify) _____

_____

_____

⎦ Minimally Impacted (recommend the above accommodations).

____ Other (please specify) _____

_____

Given the current medical condition of the patient, are there any non-academic accommodations he/she will need? Please list. (E.g. Accessible parking).

All corroborating reports (i.e. Neuro-psychoeducational reports, medical documentation) that support the reasonable accommodation recommendations suggested above are required before any accommodations are approved by the Disability Services office.

Name and contact information for Attending Physician (Please use office stamp)

Physician Signature:_____Date: _____

Please return this form to:

Office of Accessibility Services
Hood College
401 Rosemont Avenue
Frederick, Maryland 21701

Fax: 301-696-3952