SUNY MORRISVILLE
EST. 1908

Office of Accessibility Services

Telephone: (315) 684.6349 asctesting@morrisville.edu

Request for Information RE: Medical Provider Form

(The health care provider need not use this specific form, but all the information requested here is necessary for the institution to have in order to consider the request for accommodation. This form is provided for convenience.)

Student's Name:____________________DOB:_________________Expected Year of SUNY Morrisville Graduation________

Home Phone: _____________________Cell Phone:_______________________Email_________________________________

Address:____

By signing I give permission for the ASC to contact the medical provider below with any questions related to this document and request.

Student Signature (must be a wet signature):____

Please note: The above named student has indicated that you are their treating provider, who has knowledge of a disability which substantially limits a major life activity. Generally, we prefer documentation from providers in the State of NY or the student's home state who have personal knowledge of the student, consistent with their professional obligations. We ask that the practitioner who completes this form NOT be a family member, or relative of the student.

So that we may better evaluate the request for this accommodation, please answer the following questions:

Information about the Student's Disability

Federal law identifies a person with a Disability as someone who has a physical or mental impairment that ***substantially limits*** one or more major life activities. That suggests that a diagnosis (label) does not necessarily equate with a disability (substantial limitation).

What is the diagnosed condition (use table below)?:

Diagnosis	Diagnostic Code From:	Does this disability or impairment substantially limit a major life activity?	Please rate the severity of the disability or impairment	Please describe this disability of impairment
	○ DSM-5 ○ DSM-5-TR ○ ICD-9 ○ ICD-10	○ Yes ○ No ○ When Active	○ Mild ○ Moderate ○ Severe	○ Stable ○ Variable ○ Progressive
	○ DSM-5 ○ DSM-5-TR ○ ICD-9 ○ ICD-10	○ Yes ○ No ○ When Active	○ Mild ○ Moderate ○ Severe	○ Stable ○ Variable ○ Progressive
	○ DSM-5 ○ DSM-5-TR ○ ICD-9 ○ ICD-10	○ Yes ○ No ○ When Active	○ Mild ○ Moderate ○ Severe	○ Stable ○ Variable ○ Progressive

When did you first meet with the student regarding this diagnosis, and in what context (was it face to face or a virtual interaction)?_____

How was the diagnosis made? (For example, what form of assessment did you rely upon?):_____

When did you last interact with the student regarding this diagnosis?_____

Will there be any follow up appointments with the student? If yes, when is the next appointment scheduled?

_____

Does the student require ongoing treatment or medication?_____

Are you prescribing the medication / administering treatment?_____

What is the nature of the student's impairment (i.e., how is the student ***substantially limited***?) You may use additional sheets or letterhead to answer if necessary.

_____

_____

_____

How will the limitations of the disability / condition affect the student's ability to function?

_____

_____

_____

What conditions will cause the disability to manifest?

_____

_____

_____

Has the student received accommodations in the past (high school, vocational education, college)?

_____

Please make *specific recommendations* for accommodations this student will require to have equal, appropriate and reasonable access to services and programs.

_____

_____

_____

Importance of ESA to Student's Well-Being

In your opinion, how important is it for the student's well-being that an ESA be in residence on campus? What consequences, in terms of disability symptomology, may result if the accommodation is not approved?

_____

_____

This student was provided with a copy of the rules and restrictions surrounding the presence of an animal in residence in our University housing. Has the student shared those restrictions with you? Yes / No

Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities and residing in campus housing? Do you believe those responsibilities might exacerbate the student's symptoms in any way? (If you have not had this conversation with the student, we will discuss this with the student at a later date.)

_____

_____

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. The named student has signed this form (above) indicating written permission to share additional information with us in support of the request.

We recognize that having an ESA in the residence hall can be a real benefit for someone with a significant mental health disorder, but the practical limitations of a rigorous course schedule and our housing arrangements make it necessary to carefully consider the impact of the request for an ESA on both the student and the campus community.

Please provide contact information, sign and date this questionnaire (below) and return it to **ASCTesting@morrisville.edu**

Your Contact information:
Name:
Address:
Telephone:
FAX and or Email address:
Professional's Signature (must be a wet signature):
_____Date:_____
Type of License: _____ License #and State _____