PROVIDENCE COLLEGE

Medical Documentation Form

Please complete and sign the Authorization to Receive Health Care Information. This gives us permission to speak with your provider if we have questions relating to the recommendation for accommodations. Your health care provider should complete the **Health Care Provider** portion of the **Medical Documentation Form**, sign it, and return it via mail, fax or scanned and emailed.

For medical documentation of disability accommodation requests for Providence College students

Student Fills Out Authorization Below:

Student's Name: _____ Date of birth _____

Student Email: _____ Student Cell Phone: _____

AUTHORIZATION TO RECEIVE INFORMATION: I authorize the Coordinator for Students with Physical Disabilities at Providence College to receive information from the provider below. I also authorize my provider to discuss my medical condition with the Coordinator for Students with Disabilities.

Name of Provider: _____

Address (Street, City, State, & Zip): _____

Providers Office Telephone: _____

Student signature: _____ Date _____

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Health Care Provider: Please Complete and Sign Section Below:

Providence College provides reasonable accommodations and support services to students with diagnosed disabilities. A student's documentation regarding their condition must demonstrate they have a disability covered under the Americans with Disabilities Act (ADA; 1990). *The ADA defines a disability as a **physical or mental impairment that substantially limits one or more major life activities**. To determine eligibility for services and accommodations, this office requires current and comprehensive documentation of the student's disorder from the diagnosing physician or health care provider (*the provider completing this form may not be a relative of the student*). If appropriate, the provider may attach a report providing additional information. Please respond to the following items regarding the student named above:

1. What is the current diagnosis of the student's medical condition/disability?

_____

2. Date condition first diagnosed

_____

3. What is the severity of the condition?

_____ Mild _____ Moderate _____ Severe

4. How long is this condition likely to persist? _____

5. How long has the student been in your care? _____

6. Date of last visit. _____

7. Please describe current impact of condition and specific functional limitations:

_____

_____

_____

8. Please describe any accommodations that may be needed:

_____

_____

_____

Signature of Provider: _____ Date: _____

Profession/Specialty: _____

Thank you for your assistance.

After completion, this **Medical Documentation Form** should be signed and returned via mail, fax or scanned and emailed to:

Student Disability Services (non-academic)
Providence College
One Cunningham Square, Slavin Center 102
Providence, RI 02918

Fax: 401-865-1779

Email: studentdisabilityservices@providence.edu